DEPARTMENT OF THE ARMY
U.S. ARMY CRIMINAL INVESTIGATION COMMAND
Camp Cropper CID Office
24th/348th MP DET (CID), Camp Cropper, Iraq APO AE 09342

29 Oct 2008

MEMORANDUM FOR: SEE DISTRIBUTION

SUBJECT: CID REPORT OF INVESTIGATION - 1ST FINAL SUPPLEMENTAL/SSI - 0022-2008-CID789-53207 - 5H9A

DATES/TIMES/LOCATIONS OF OCCURRENCES:
1. 31 JUL 2008, 1605 - 31 JUL 2008, 1605; INTENSIVE CARE UNIT, 115TH COMBAT SUPPORT HOSPITAL, CAMP CROPPER, IRAQ, AE 09342

DATE/TIME REPORTED: 31 JUL 2008, 1614

INVESTIGATED BY:
SA (b)(2),(b)(5),(b)(7)(C)
SA
SA

SUBJECT:
1. NONE, ; [DEATH BY NATURAL CAUSES] (NFI)

VICTIM:
1. HASAN, MAHMUD RASHID (DECEASED); FRCIV; IRAQ; (DOB); (POB); MALE; OTHER; INTERNMENT SERIAL NUMBER (b)(6),(b)(7)(C), THEATER INTERNMENT FACILITY (TIF), CAMP CROPPER, IRAQ, ARMED FORCES AFRICA, CANADA, EUROPE & MIDDLE EAST 09342; XZ ; [DEATH BY NATURAL CAUSES]

INVESTIGATIVE SUMMARY:

The Patient Administration Department, 115th CSH, reported the death of Detainee HASAN.

Investigation determined Mr. HASAN died as a result of Lung Cancer with Brain Metastasis, and the manner of death was natural.

Further Investigation by the Office of the Armed Forces Medical Examiner determined Mr. HASAN died as result of Metastatic Carcinoma with tumor involvement to the lungs, liver, and kidneys, and the manner of death was natural. This report concurred with the investigative findings.

EXHIBITS:

Added Attached:

14. Agent's Investigation Report (AIR) of SA (b)(6),(b)(7)(C) 28 Oct 08.

15. Autopsy Examination Report, 10 Oct 08.

16. Report of Toxicological Examination, 11 Aug 08.

17. Certificate of Death (Overseas), 24 Oct 08.

The originals of Exhibits 14-17 are retained in the files of the Office of the Armed Forces Medical Examiner, 1413 Research Boulevard, Building 102, Rockville, MD 20850.

Not Attached:

None.

STATUS: This is a 1st Final Supplemental Report. No Further investigative activity is anticipated at this time.

CID Reports of Investigation may be subject to a Quality Assurance Review by CID higher headquarters.

Report Prepared By:

(b)(6),(b)(7)(C)

Special Agent

Report Approved By:

(b)(6),(b)(7)(C)

Special Agent in Charge

DISTRIBUTION:
Dir, USACRC, Ft Belvoir, VA
CDR, USACIDC, ATTN: CIOP-COP-CO, Fort Belvoir, VA 22060
CDR, 24th/348th MP DET (CID), Camp Slayer, Iraq APO AE 09342
Operations Officer, 34th/348th MP DET (CID), Camp Slayer, Iraq APO AE 09342
CDR, 10th MP BN (CID), Camp Victory, Iraq, APO AE 09342
CDR, 3D MP GRP (CID), USACIDC, Fort Gillem, GA 30297
DIR, AFIP, OAFME WASH
CJA, 11th MP BDE, ATTN: LTC (b)(6),(b)(7)(C) Camp Cropper, Iraq APO AE 09342
PMO, Camp Victory, Iraq APO AE 09342
FILE

DEPARTMENT OF THE ARMY
U.S. ARMY CRIMINAL INVESTIGATION COMMAND
Camp Cropper CID Office
24th/348th MP DET (CID), 10th MP BN (CID), Camp Cropper, Baghdad, Iraq
APO AE 09342

13 Oct 2008

MEMORANDUM FOR: SEE DISTRIBUTION

SUBJECT: CID REPORT OF INVESTIGATION - FINAL (C)/SSI - 0022-2008-CID789-53207 - 5H9A

DATES/TIMES/LOCATIONS OF OCCURRENCES:
1. 31 JUL 2008, 1605 - 31 JUL 2008, 1605; INTENSIVE CARE UNIT, 115TH COMBAT SUPPORT HOSPITAL, CAMP CROPPER, IRAQ, AE 09342

DATE/TIME REPORTED: 31 JUL 2008, 1614

INVESTIGATED BY:
SA (b)(2),(b)(6),(b)(7)(C)
SA
SA

SUBJECT:
1. NONE, ; [DEATH BY NATURAL CAUSES] (NFI)

VICTIM:
1. HASAN, MAHMUD RASHID (DECEASED); FRCIV; IRAQ; (DOB); (POB); MALE; OTHER; INTERNMENT SERIAL NUMBER (b)(6),(b)(7)(C) THEATER INTERNMENT FACILITY (TIF), CAMP CROPPER, IRAQ, ARMED FORCES AFRICA, CANADA, EUROPE & MIDDLE EAST 09342; XZ ; [DEATH BY NATURAL CAUSES]

INVESTIGATIVE SUMMARY:

THIS IS AN OPERATION IRAQI FREEDOM INVESTIGATION.

The Patient Administration Department, 115th CSH, reported the death of Detainee HASAN.

Investigation determined Mr. HASAN died as a result of Lung Cancer with Brain Metastasis, and the manner of death was natural.

EXHIBITS:

Attached:

1. Agent's Investigation Report (AIR) of SA (b)(6),(b)(7)(C) 8 Aug 08.
2. Medical Records of Mr. HASAN.
3. Certifcate of Death of Mr. HASAN, 31 Jul 08
4. AIR of SA (b)(6),(b)(7)(C) 31 Jul 08.
5. Rough Sketch depicting Human Remains, 31 Jul 08.
6. AIR of SA (b)(6),(b)(7)(C), 5 Aug 08.
7. AIR of SA (b)(6),(b)(7)(C) 29 Sep 08.
8. Medical Records of Mr. HASAN.
9. Memorandum For Record, 31 Jul 08.
10. Convoy List Of Remains Of Deceased Personnel, 20 Aug 08
11. Receipt of Remains, 20 Aug 08.
12. Photographic Packet (Examination of Remains) (USACRC, USACIDC, and file copy only).
13. CD containing original images (Autopsy) (USACRC, USACIDC, and file copy only).

The originals of Exhibits 1 and 4-7, and 12 are forwarded with the USACRC copy of this report. The originals of Exhibits 2, 3, 8, and 9 are retained in the files of TF115 CSH, Camp Cropper, Iraq APO AE 09342. The originals of Exhibit 10 and 11 are retained in the files of 111th QM CO, Mortuary Affairs, Camp Sather, Iraq APO AE 09342. The original of Exhibit 13 is retained in the files of the Office of the Armed Forces Medical Examiner, 1413 Research Boulevard, Building 102, Rockville, MD 20850.

Not Attached:

None.

STATUS: This is a Final (C) Report.

CID Reports of Investigation may be subject to a Quality Assurance Review by CID higher headquarters.

6

Report Prepared By:

(b)(6),(b)(7)(C)

Special Agent

Report Approved By:

(b)(6),(b)(7)(C)

Special Agent in Charge

DISTRIBUTION:
Dir, USACRC, Ft Belvoir, VA
CDR, USACIDC, ATTN: CIOP-COP-CO, Fort Belvoir, VA 22060
Commander, 24th/348th Military Police Detachment, Camp Slayer, Baghdad, Iraq APO AE 09342
Operations Officer, 34th/348th MP DET (CID), Camp Slayer, Baghdad, Iraq APO AE 09342
Commander, 10th MP BN (CID) (FWD), Camp Victory, Baghdad, Iraq, APO AE 09342
Commander, 3D MP GRP (CID), USACIDC, Fort Gillem, GA 30297
Director, Armed Forces of the Institute of Pathology, Office of the Armed Forces Medical Examiner, A
Dover Facility, Dover Air Force Base, Delaware
CID LIAISON, AFIP, ATTN: SA (b)(6),(b)(7)(C)
Special Agent in Charge, Aberdeen Proving Ground CID Office
FOB Commander, 1-114 Field Artillery, ATTN: LTC (b)(6),(b)(7)(C) Camp Cropper, Baghdad, Iraq APO AE 09
Executive Officer, 115th Combat Support Hospital, Camp Cropper, Baghdad, Iraq APO AE 09342
Command Judge Advocate, 11th Military Police Brigade, ATTN: LTC (b)(6),(b)(7)(C)
Camp Cropper, Baghdad, Iraq
PMO, VBC, IRAQ, APO AE 09342
FILE

7

AGENT'S INVESTIGATION REPORT

CID Regulation 195-1

ROI NUMBER 0022-08-CID789-53207

PAGE 1 OF 1 PAGE

DETAILS

BASIS FOR INVESTIGATION: About 1614, 31 Jul 08, LTC [redacted] Patient Administration Department, 115th CSH, reported the death of Mr. HASAN.

About 1630, 31 Jul 08, SA [redacted] interviewed Dr. (MAJ) [redacted] Attending Physician, ICU, 115th CSH, who related Mr. HASAN was admitted to the ICU on 29 Jul 08, for numerous ailments, to include weakness, nausea, headaches, and a cough. Dr. [redacted] stated Mr. HASAN was diagnosed with pneumonia and placed on antibiotics. The second day after being admitted into the CSH, Mr. HASAN became drowsy and by that evening became unresponsive. By the third day, Mr. HASAN had dilated pupils and was pronounced deceased at 1605, 31 Jul 08. Dr. [redacted] verified Mr. HASAN was deceased when he determined Mr. HASAN had fixed and dilated pupils, no heart beat or lung sounds, and Mr. HASAN demonstrated asystole on the EKG. Dr. [redacted] opined the cause of Mr. HASAN's death was lung cancer with brain metastasis, and the manner of death was natural.

About 0750, 1 Aug 08, SA [redacted] coordinated with SPC [redacted] PAD, 115th CSH, and submitted a Request for Private Medical Information pertaining to the inpatient records of Mr. HASAN.

About 1550, 8 Aug 08, SA [redacted] coordinated with PV2 [redacted] PAD, 115th CSH, who provided all medical documentation and the Certificate of Death pertaining to Mr. HASAN. A review of the records indicated Mr. HASAN was admitted to the ICU, 115th CSH on 29 Jul 08, for numerous ailments which were caused by terminal lung cancer with metastasis to the brain. Mr. HASAN's physical state deteriorated over the course of his treatment until his death on 31 Jul 08. ///Last Entry///

TYPED AGENT'S NAME AND SEQUENCE NUMBER	ORGANIZATION
For SA [redacted]	20th/1149th Military Police Detachment (CID)(FWD) Camp Cropper, Baghdad, Iraq APO AE 09342
SIGNATURE [redacted]	DATE 08 Aug 08 / EXHIBIT 1

CID FORM 94 (Automated)

FOR OFFICIAL USE ONLY
LAW ENFORCEMENT SENSITIVE

Exhibit(s) 2 and 3

Page(s) 000009 thru 000057 referred to:

CDR U.S. Army Medical Command
Freedom of Information/Privacy Act Office
ATTN: MCFP Bldg 126 Stop 76
1216 Stanley Road 2nd Floor
Fort Sam Houston, TX 78234-5049

HOSPITAL REPORT OF DEATH

NAME AND LOCATION OF HOSPITAL

To accompany Medical Officer in attendance will.
Send form, without delay to the Registrar or Administrative Officer of the Day, for necessary action and for preparation of required number of copies.

Prepare, in duplicate, items 1 through 10 and sign item 11. Print or type entries.

SECTION A - ATTENDING MEDICAL OFFICER'S REPORT

PERSONAL DATA

1. PATIENT DATA *(Patient's ward plate will be used to imprint identifying data if available)*

Patient's name (Last, first, middle initial) Grade, Social Security Account No., Register Number and Ward Number

2. TIME OF DEATH *(Hour-day-month-year)*
1605 - 31 July 2008

3. MEDICAL EXAMINER/CORONER'S CASE ☐ YES ☐ NO

4. RELIGION

5. CHAPLAIN NOTIFIED ☐ YES ☐ NO

6. NAME, ADDRESS AND RELATIONSHIP OF RELATIVE OR FRIEND PRESENT AT DEATH

CAUSE OF DEATH

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
7a. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury, or complication which caused death)*	DUE TO *(or as a consequence of)* Lung cancer with brain metastasis	1 year
7b. ANTECEDENT CAUSES *(Morbid conditions, if any, giving rise to the above cause, stating the underlying condition last)*	DUE TO *(or as a consequence of)* (1)	
	(2)	
8. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT	a.	
	b.	

9. DATE 31 July 08

10. TYPED OR PRINTED NAME AND GRADE OF MEDICAL OFFICER (b)(6)

11. SIGNATURE OF MEDICAL OFFICER IN ATTENDANCE (b)(6)

SECTION B - ADMINISTRATIVE ACTION

TYPE OF ACTION	HOUR	DAY	MONTH	YEAR	INITIALS OF RESPONSIBLE OFFICER
12. TELEGRAM TO NEXT OF KIN OR OTHER AUTHORIZED PERSON					
13. POST ADJUTANT GENERAL NOTIFIED					
14. IMMEDIATE CO OF DECEASED NOTIFIED					
15. INFORMATION OFFICE NOTIFIED					
16. POST MORTUARY OFFICER NOTIFIED					
17. RED CROSS NOTIFIED					
18. OTHER *(Specify)*					
19.					

SECTION C - RECORD OF AUTOPSY

20. AUTOPSY PERFORMED *(If yes, give date and place)* ☐ YES ☐ NO

21. AUTOPSY ORDERED BY *(Signature)*

22. PROVISIONAL PATHOLOGICAL FINDINGS

23. DATE

24. TYPED NAME AND GRADE OF PHYSICIAN PERFORMING AUTOPSY

25. SIGNATURE OF PHYSICIAN PERFORMING AUTOPSY

26. DATE

27. TYPED NAME AND GRADE OF REGISTRAR

28. SIGNATURE OF REGISTRAR

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LAW ENFORCEMENT SENSITIVE

DA FORM 3894, OCT 72 REPLACES DA FORM 8-257, 1 JAN 61, WHICH WILL BE USED. EXHIBIT

ACLU DDII CID ROIS 37219

[redacted] PROFILER

Personal Data Privacy Act of 1974 (PL 93-579)

Progress Notes

Report requested by: (b)(6)

[redacted] 2008071623 INPT Register # (b)(6) PHYSICIAN NOTES

(b)(6)

Paged by nursing staff approximately 1555 as patient SaO2 was in 70's. Upon arrival to bedside at 1608, (b)(6) from the ER had been called and pronounced patient deceased at 1605. My exam confirmed this, as patient had fixed and dilated pupils, no heart sounds or lung sounds, EKG demonstrated asystole and patient was pronounced deceased. Appropriate paper work to be completed and authorities notified.

(b)(6)

ICU/ICW Attending

Signed: (b)(6)

(b)(6)

Reg #: (b)(6)

CROP,ISN315224
01 Jan 1967 / Male
Loc: ICU 1
Spon: CROP,ISN315224
Unit:

FOREIGN NATIONAL - POW/INTERNE
H: not on file
W: not on file
Rank:
RR:

Automated version of SF509

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LAW ENFORCEMENT SENSITIVE

EXHIBIT 2

ACLU DDII CID ROIS 37220

1. LAST NAME-FIRST NAME-MIDDLE INITIAL	2. GRADE
	3. SOCIAL SECURITY NO.
4. ORGANIZATION	5. WARD

6. DEATH OCCURRED				7. PLACE WHERE DEATH OCCURRED
HOUR	DAY	MO.	YEAR	

AUTHORIZED SIGNATURE

(b)(6)

DA FORM 3910 REPLACES DA FORM 3015, 1 MAR 63, WHICH WILL BE USED. For use of this form see, AR 40-400; the proponent agency is OTSG.

DEATH TAG

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LAW ENFORCEMENT SENSITIVE

EXHIBIT 2

ACLU DDII CID ROIS 37221

0 12 08-CID789-53207

ADMISSION COVER WORKSHEET

Name: CROP, ISN315224

FMP/SSN:

Date/Time: 30 Jul 1908@0147
Sex: MALE

ADMISSION
Source: EPA
Age: 41

MEPRS: AAAA
DOB: 01 Jan 1967 Ward:

Patient Category: FRGN NAT POW/INTERNEE
Marital Status: UNKNOWN
Duty Zip:
Sponsor Name: CROP, ISN315224

Pay Grade: Fly Status:
Race: UNKNOWN
Ethnic: OTHER
Religion:

MTF Trans from:
MTF of Initial Adm:
Disposition Date: 31 Jul 2008@1736

Init Adm Date:
Type of Disposition: DIKD

Sponsor Name: CROP, ISN315224
Adm Physician: (b)(6)
Adm Diagnosis: pneumonia, met lung ca
Adm Proc1:
Adm Proc2:

Administrative Remarks:

Cause of Injury:

Principle Dx:

Other Dx:

Principle Procedure:

Other Procedure:

Patient has a Living Will/Advance Directive on file at MTF. Yes___ No___

Signature Attending Medical Officer ___

*** End of Report ***

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Law Enforcement Sensitive

EXHIBIT 2

ACLU DDII CID ROIS 37222

0022-03-CID789-53007

Progress Notes

Note entered by (b)(6)

Date 20080419 Time [illegible] Register # (b)(6) CLINICAL NURSE
-OB NOTES
30 JUL 2003 @ 0420. Admission note. Admitted a 43 Y/O male from ER via cart. A&OX3. PERRLA. Mucous membranes moist/pink. Resp. slightly labored with exertion, lungs with fine rales RLL and diminished sounds LLL. Denies cough. Abd. SNT, bowel sounds +X4 quads. IV patent in left hand and infusing NSS @ 125cc/hr without sx of infection noted. Denies pain/discomfort at this time, will continue to monitor. VSS (b)(6)

Signed: (b)(6) (b)(6)

3 Jul 03 - [illegible] infiltrate (1) hand. Restarted [illegible] prep [illegible]
(2) Days
(2) Return with [illegible] good [illegible]

(b)(6)

20/(b)(6) 0 CROP,ISN315224 FOREIGN NATIONAL - POW/INTER
Reg # (b)(6) 01 Jan 1967 / Male H: not on file
Loc: ICW 1 W: not on file
Spon: CROP,ISN315224 Rank:
Unit: RR:
Automated version of SF509

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EXHIBIT 2

ACLU DDII CID ROIS 37223

(b)(6)

(b)(6) CLINICAL NOTES

Nursing: Pt with lung cancer and mets to brain, some AMS noted. Approximately 1750 had difficulty waking patient up to take meds. PS was [illegible] VSS (see flowsheet). O2 SATs 94% which is consistent with baseline. (b)(6) notified. Foley placed earlier in shift using sterile technique, pt tolerated well. No other issues at this time, will continue to monitor.

Signed: (b)(6)

(b)(6)

Res #: (b)(6)

CROP, ISN315224
01 Jan 1967 / Male
Loc: ICW 1
Spon: CROP, ISN315224
Unit:

FOREIGN NATIONAL - POW/INTL
H: not on file
W: not on file
Rank:
RR:

Automated version of SF509

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Law Enforcement

EXHIBIT 2

ACLU DDII CID ROIS 37224

MEDICAL RECORD | PROGRESS NOTES

DATE	NOTES
30 July 03 2250	PT had a copious continuous episode x1 of emesis. MD from ER was informed. MD is at bedside of PT. 4mg of Zofran IV was given. V.S. WNL. PT had an episode of syncope, seizure like. MD order to give 1mg IV x1 of Ativan. MD transferred PT to ICU. PT in bed, non-reactive to verbal. PT reactive to touch. Pupils 2mm reactive to light. PT is not alert to person, time or place. (b)(6)
31 July 03 0535	Received report - Terminal c̄ Kentucky Derby Days with mean a.s.t. Deepest hemiation with increased intracranial pressure. CR. Dense Hemi OT 2 Dilated 3 fixed. I agree with (b)(6) that early aggressive intervention may be feasible. A. Terminal P. Chris Lemmette commander MC USN (b)(6)

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME: LAST | FIRST

(b)(6)

DEPARTMENT/SERVICE | HOSPITAL OR MEDICAL FACILITY

Chief Nurse Exec

PATIENT'S IDENTIFICATION (For typed or written entries, give: Name (last, first, middle); SS No. or SSN; Sex; Date of Birth; Rank/Grade) | REGISTER NO.

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5-1)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.206(b)

(b)(6)

325224
ICW #7

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Law Enforcement

2

Progress Notes

Date of Call 20080230 - 20 Jan

Called Generated by LICIR (b)(6) -08-CID789-55207

Reg # 20080230 INPT Register # (b)(6) FEISTMAN

Progress NOTES

Called in by DR physician approximately 2300 as nursing staff found patient to be unresponsive. VS were stable but patient had non purposeful movements and asymmetric pupils (R>L), had flexion/withdrawal movement with sternal rub. Lytes were WNL from this am, oxygen saturation ~95% prior to evaluation. Patient was transferred to the ICU for supportive care, oxygen, and was loaded with fosphenytoin. Patient with lung cancer w/ known multiple mets. Suspect patient either bleed into one of lesions or has progression of disease with vasogenic edema. Given disease and prognosis with no chance of improvement or survival without definitive surgery/chemotherapy, or radiation, will make patient DNR/DNI and treat supportively. Case discussed with (b)(6) Browder, ER staff, who also reviewed case, examined patient, who agrees with this assessment.

(b)(6)

Signed: (b)(6)

*** END OF REPORT ***

(b)(6)

Reg # (b)(6)

CROP,ISN315224
01 Jan 1967 / Male
Loc: ICU 1
Spon: CROP,ISN315224
Unit:

FOREIGN NATIONAL - POW/INTERNE
H: not on file
W: not on file
Rank:
RR:

Automated version of SF509

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2

ACLU DDII CID ROIS 37226

0 12-08-CID789-5 5 1 0 7

Diagnosis.

Nausea: Y / N Vomiting: Y / N Diarrhea: Y / N Recent Weight Loss: Y

Anorexia: NO YES (list)

Age: Gender: Ht: Wt: Bmi: IBW:

Diet: American Food (if authorized): YES

Special Dietary Needs:

Meds:

Labs: Glucose NA+ 141 K+ Albumin Total Pro

BUN Creatine

A/P:

Nutrition Risk: Patient determined to be at low nutrition risk; will be re-screened in one week

Patient determined to be at nutrition risk secondary to :

Further intervention by RD needed within 72 hours

Re-Screen Date:

(b)(6)

PATIENT'S P... (Do not place in Mechanical

RECORDS MAINTAINED

PATIENT'S NAME (Last, First, Middle Initial) SEX

RELATIONSHIP TO SPONSOR STATUS MARITAL STA

SPONSOR'S NAME ORGANIZATION

DEPART./SERVICE SSN/IDENTIFICATION NO. DATE OF BIRTH

CHRONOLOGICAL RECORD OF MEDICAL CARE STANDARD FORM 600 (Rev 5-84)

0024-00-CID789-55207

Date/Time: Position/Title: Unit: Email:

Unit: 3rd Neuchor

Diagnosis:

Nausea: Y / N Vomiting: Y / N Diarrhea: Y / N Recent Weight Loss:

Allergies: NO YES (list)

Age: Gender: Ht: Wt: BMI: UBW:

Diet: American Food (if authorized): YES

Special Dietary Needs:

Meds:

Labs: Glucose NA+ K+ Albumin Total Pro

BUN Creatine

A/P:

Nutrition Risk: Patient determined to be at low nutrition risk; will be re-screened in one week

Patient determined to be at nutrition risk secondary to :

Further intervention by RD needed within 72 hours

Re-Screen Date:

(b)(6)

(b)(6)

PATIENT'S IDENTIFICATION (Use this space for Mechanical)

RECORDS MAINTAINED AT:

PATIENT'S NAME (Last, First, Middle Initial) SEX

RELATIONSHIP TO SPONSOR STATUS RANK/GRADE

SPONSOR'S NAME ORGANIZATION

DEPART./SERVICE SSN/IDENTIFICATION NO. DATE OF BIRTH

CHRONOLOGICAL RECORD OF MEDICAL CARE STANDARD FORM 600 (Rev 5-84)

NOT OFFICIAL USE ONLY

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EXHIBIT

ACLU DDII CID ROIS 37228

MEDICAL RECORD - PROVIDER ORDERS

For use of this form, see MEDCOM Circular 40-6

DIRECTIONS: The provider will DATE, TIME, and SIGN each order or set of orders recorded. Only one order is authorized per line. Orders completed during the shift in which they are written will be signed off adjacent to the order and do not require recording on other PR forms.

DATE/ TIME	ORDERS (SIGNATURE REQUIRED FOR EACH ORDER/SET OF ORDERS. SIGNATURE MUST BE LEGIBLE; PROVIDER WILL USE SIGNATURE STAMP OR PRINT NAME)
	Sliding Scale Insulin:
	( ) Target Glucose Range 70-120 mg/dL
	<70 mg/dL = give 1 Amp D50 IVP & call MD
	70-120 mg/dL = no action
	121-150 mg/dL = 2 units Regular Insulin SC
	151-200 mg/dL = 4 units Regular Insulin SC
	201-250 mg/dl = 6 units Regular Insulin SC
	251-300 mg/dL = 8 units Regular Insulin SC
	301-350 mg/dL = 10 units regular Insulin SC
	>350 mg/dL = call MD
	(X) Target Glucose Range 70-180 mg/dL
	<70 mg/dL = give 1 Amp D50 & call MD
	70-180 mg/dL = no action
	181-200 mg/dL = 2 units Regular Insulin SC
	201-250 mg/dL = 4 units Regular Insulin SC
	251-300 mg/dL = 6 units Regular Insulin SC
	301-350 mg/dL = 8 units regular Insulin SC
	351-400 mg/dL = 10 units Regular Insulin SC
	>400 mg/dL = call MD
	(X) Fingersticks AC & HS
	( ) Draw HbA1c
	( )
	( )
	( )

(b)(6)

PATIENT IDENTIFICATION (Use typed or written entries note: Name - last, first, middle initial, [illegible] hospital or medical facility)

(b)(6)

ICW, Bed 7

Complete the following information on page 1 of provided orders only. Note any changes on subsequent pages.

Diagnosis: _____

Height: _____ Weight: _____ Diet: _____

Allergies: _____

Nursing Unit	Room No.	Bed No	Page No

MEDCOM FORM 688-R (TEST) (MCHO) JUN 03 Official PREVIOUS EDITIONS ARE OBSOLETE. MC V2.00

EXHIBIT 2

Law Enforcement Sensitive

ACLU DDII CID ROIS 37229

ABBREV[illegible] MEDICAL RECORD

0[illegible]2-03-CID789-52207

2. CHIEF COMPLAINT, PERTINENT HIST[illegible], AND PERTINENT SYSTEM REVIEW

3. PHYSICAL EXAMINATION *(Including pertinent positives and negatives)*

4. IMPRESSION *(Enter admission note with plan on progress notes)*

5. ADMITTING OFFICER

a. SIGNATURE	b. DATE SIGNED *(YYYYMMDD)*

6. DISCHARGE NOTE *(Brief hospital course, diagnoses, procedures, condition on discharge, pertinent discharge information (including medications, diet, activity limitations, follow-up instructions).)*	7. DISCHARGE DATE *(YYYYMMDD)*

8. DISCHARGING OFFICER

a. NAME *(Last, First, Middle Initial)*	b. GRADE	c. TITLE	d. SIGNATURE

9. PATIENT IDENTIFICATION *(For typed or written entries: Name (last, first, middle), grade, SSN, date of birth, hospital or medical facility, ward number, and register number)*	10. OUTPATIENT/HEALTH RECORD MAINTAINED AT:
(b)(6)	11. COPY PLACED IN OUTPATIENT RECORD *(X when done)*

DD FORM 2770, APR 1998 (EG)

Designed using Perform Pro, WHS/DIOR, [illegible]

For Official Use Only
Law Enforcement Sensitive

ACLU DDII CID ROIS 37230

0022 03-CID789-53007

MEDICAL RECORD - PROGRESS ORDERS

USE ONLY FOR ENTRY OF ORDERS IF PROGRESS NOTES ARE ENTERED ON FORM 4256

ITEM 6 - ENTER ORDER NUMBER IN COLUMN INDICATED BY ARROW BELOW.

(b)(6)

31524

DATE OF ORDER	TIME OF ORDER	DATE ORDER NOTED AND SIGN
31 July 08	0540	
Effective Immediately		

(b)(6)

NURSING UNIT	ROOM NO.	BED NO.	DATE OF ORDER	TIME OF ORDER
PATIENT IDENTIFICATION				HOURS

NURSING UNIT	ROOM NO.	BED NO.	DATE OF ORDER	TIME OF ORDER
PATIENT IDENTIFICATION				HOURS

NURSING UNIT	ROOM NO.	BED NO.	DATE OF ORDER	TIME OF ORDER
PATIENT IDENTIFICATION				HOURS

NURSING UNIT	ROOM NO.	BED NO.	DATE OF ORDER	TIME OF ORDER

DA FORM APR 58 4256 REPLACES EDITION OF 1 JUL 57 WHICH MAY BE USED UNTIL EXHAUSTED

For Official Use Only

Law Enforcement Sensitive

ACLU DDII CID ROIS 37231

MEDICAL RECORD - DOCTOR'S ORDERS

DATE OF ORDER | TIME OF ORDER

3 July 03 | 1620 HOURS

(b)(6)

NURSING UNIT | ROOM NO. | BED NO.

ICU

PATIENT IDENTIFICATION

(b)(6)

DATE OF ORDER | TIME OF ORDER

HOURS

(b)(6)

(b)(6)

(b)(6)

NURSING UNIT | ROOM NO. | BED NO.

ICU | | 7

PATIENT IDENTIFICATION

(b)(6)

DATE OF ORDER | TIME OF ORDER

July 30, 2003 HOURS

(b)(6)

(b)(6)

NURSING UNIT | ROOM NO. | BED NO.

ICU | | 7

PATIENT IDENTIFICATION

(b)(6)

DATE OF ORDER | TIME OF ORDER

HOURS

(b)(6)

NURSING UNIT | ROOM NO. | BED NO.

ICU | | 7

(b)(6)

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED.

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Law Enforcement Sensitive

CLINICAL RECORD - DOCTOR'S ORDERS

(b)(6)

(b)(6)

325224

DATE OF ORDER: 30 July | TIME OF ORDER: 2355 HOURS

1. Tylenol 650 mg PO Q 6 hrs PRN Temp
2. Place foley x 1 now
3. SSI (see flow sheet)

(b)(6)

(b)(6)

NURSING UNIT: ICW | ROOM NO.: | BED NO.: 7

PATIENT IDENTIFICATION

(b)(6)

(b)(6)

DATE OF ORDER: 30 July 08 | TIME OF ORDER: 0953 HOURS

(b)(6)

(b)(6)

325224

1. PA/LAT CXR x 1 today
2. SCD's to bilateral LE's

(b)(6)

NURSING UNIT: ICW | ROOM NO.:

PATIENT IDENTIFICATION

(b)(6)

(b)(6)

DATE OF ORDER: 30 July 08 | TIME OF ORDER: 1000 HOURS

(b)(6)

325224

1. D/C Avelox x 1
2. Levaquin 750 mg IV QD
   2 - First dose now

(b)(6)

NURSING UNIT: ICW | ROOM NO.: | BED NO.: 7

PATIENT IDENTIFICATION

(b)(6)

(b)(6)

DATE OF ORDER: 30 July 08 | TIME OF ORDER: 1130 HOURS

60000504

325224

1. Percocet 5/325 mg
   1 PO Q 6 hrs PRN pain

(b)(6)

(b)(6)

NURSING UNIT: ICW | ROOM NO.: | BED NO.: 7

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 78 WHICH MAY BE USED.

Allergy: _____ Weight Bearing Status: _____

Diet: ( ) NPO ( ) Regular ( ) S/S ( ) Clear Liquid ( ) Diabetic ( ) PO after midnight ( ) Ensure (HS)

Dressing: ( ) _____ ( ) Dry ( ) Wet ( ) PRN ( ) Saline ( ) Wet-Dry

Continuous Wound Vac to _____ ( ) 75 mmHg ( ) 125 mmHg ( ) 200 mmHg

Drains: ( ) NGT to LWS ( ) Chest Tube to _____ ( ) Hemovac ( ) JP ( ) Foley ( ) Record output q8 hrs

Labs: ( ) CBC ( ) CRP ( ) ESR ( ) Digs ( ) ABG ( ) CMP ( ) BMP ( ) Other: _____
( ) NOW ( ) in AM ( ) q AM ( ) q AM x 3 days

X-Rays: _____

MEDICATIONS

(b)(6)

( ) Saline Lock w/flush q 8 hrs ( ) NS ( ) LR @ _____ ml/hr ( ) D5 1/2 NS @ _____ ml/hr
( ) Other IV Fluid: _____
( ) Lovenox 40mg SQ daily ( ) Lovenox - Weight Based _____ mg SQ BID ( ) Hold PM dose the night before surgery
( ) Zosyn 3.375 grams IV q 8 hours
( ) Zosyn 4.5 grams IV q 8 hours
( ) Unasyn 3 grams IV q 6 hours
( ) Ancef 1 gram IV q 8 hours
( ) Ancef 1 gram IV x 1 on chart for OR
( ) Vancomycin 1 gm IV q 12 hours
( ) Levofloxacin 500 mg daily ( ) PO ( ) IV
( ) Cefoxitin ( ) 1 gram IV q 6 hours ( ) 2 gm IV q 8 hours
( ) MS Contin _____ mg PO q 12 hours
( ) Zantac ( ) 150 mg PO BID ( ) 50 mg IV q 8 hours
( ) Colace ( ) 100 mg PO BID ( ) 200 mg PO BID
( ) Dulcolax 10 mg ( ) PO ( ) Supp PR ( ) q AM ( ) BID ( ) Other: _____

(b)(6)

(b)(6)

PRN MEDICATIONS

( ) Percocet 1-2 tablets PO q 6 hours PRN pain
( ) Morphine 2-8 mg IV q 1 hour PRN severe pain or while NPO
( ) Tylenol 650 mg ( ) PO ( ) Supp PR q 4 hours PRN for pain, fever, headache, do NOT give it within 4 hrs of Percocet
( ) Motrin ( ) 400 mg ( ) 800 mg PO q 8 hours PRN for pain, fever, headache
( ) Benadryl ( ) 25 mg ( ) 50 mg ( ) 25 - 50 mg PO / IV / IM ( ) q 4 hours ( ) q 8 hours PRN itch or insomnia
( ) Reglan 10 mg IV / PO q 6 hours PRN nausea
( ) Zofran 4 mg IV q 6 hours PRN nausea

ADDITIONAL ORDERS

Consent and Witness Consent

(b)(6)

PREPARED BY: _____ DATE (yyyymmdd) 20080101

Fort Campbell Support Hospital

PATIENT'S IDENTIFICATION (Typed or written entries given: Name (Last, First, Middle); Grade; Date; Hospital or Medical Facility)

(b)(6)

PSUEDO ISN: _____ ISN: 385224

( ) HISTORY / PHYSICAL
( ) OTHER EXAMINATION
( ) DIAGNOSTIC STUDIES
( ) TREATMENT

( ) FLOW CHART
(X) OTHER (specify) *Provider Orders*

LOCATION: ( ) ICU (X) ICW BED # 7 AGE

MEDCOM FORM 4700 FEB 2003

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EXHIBIT 2

ACLU DDII CID ROIS 37234

MEDICAL RECORD - SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-66; the proposent agency is the Office of The Surgeon General

REPORT TITLE: PROVIDER ORDERS

OTSG APPROVED (Date)

DATE: [illegible] TIME: [illegible]

SERVICE: (X) MED ( ) SURG ( ) ORTHO ( ) POM

DIAGNOSIS: [illegible]

CONDITION: ( ) STABLE (X) CRITICAL ( ) GUARDED

Vital Signs: ( ) ICW Protocol ( ) ICU Protocol

Allergies: _____ (X) NKDA

Activity: Bedrest

Weight Bearing Status: _____

Diet: (X) NPO ( ) Regular ( ) Soft ( ) Clear Liquid ( ) Diabetic ( ) NPO after midnight for surgery DOS. _____

Dressing Change: ( ) POD # _____ ( ) Daily ( ) BID ( ) PRN ( ) Dakins ( ) Wet-Dry ( ) Xeroform-Dry

Continuous Wound Vac to _____ ( ) 75 mmHg ( ) 125 mmHg ( ) 150 mmHg

Drains: ( ) NGT to LWS ( ) Chest Tube to _____ ( ) Hemovac ( ) JP ( ) Foley ( ) Record output q 8hrs

Labs: ( ) CBC ( ) CRP ( ) ESR ( ) Coags ( ) ABG ( ) CMP ( ) BMP ( ) Other _____
( ) NOW ( ) in AM ( ) q AM ( ) q AM x 3 days

X-Rays: _____

MEDICATIONS

( ) Saline Lock w/flush q 8 hrs (X) NS ( ) LR @ _____ ml/hr ( ) D5 1/2 NS @ [illegible] ml/hr
( ) Other IV Fluid: _____
( ) Lovenox 40mg SQ daily ( ) Lovenox - Weight Based _____ mg SQ BID ( ) Hold PM dose the night before surgery
( ) Zosyn 3.375 grams IV q 6 hours
( ) Zosyn 4.5 grams IV q 8 hours
( ) Unasyn 3 grams IV q 6 hours
( ) Ancef 1 gram IV q 8 hours
( ) Ancef 1 gram IV x 1 on chart for OR
( ) Vancomycin 1 gm IV q 12 hours
( ) Levofloxacin 500 mg daily ( ) PO ( ) IV
( ) Cefoxitin ( ) 1 gram IV q 6 hours ( ) 2 gm IV q 8 hours
( ) MS Contin _____ mg PO q 12 hours
(X) Zantac ( ) 150 mg PO BID (X) 50 mg IV q 8 hours
( ) Colace ( ) 100 mg PO BID ( ) 200 mg PO BID
( ) Dulcolax 10 mg ( ) PO ( ) Supp PR ( ) q AM ( ) BID ( ) Other: _____

PRN MEDICATIONS

( ) Percocet 1-2 tablets PO q 6 hours PRN pain
( ) Morphine 2-8 mg IV q 1 hour PRN severe pain or while NPO
( ) Tylenol 650 mg ( ) PO ( ) Supp PR q 4 hours PRN for pain, fever, headache, do NOT give it within 4 hrs of Percocet
( ) Motrin ( ) 400 mg ( ) 800 mg PO q 8 hours PRN for pain, fever, headache
( ) Benadryl ( ) 25 mg ( ) 50 mg ( ) 25 - 50 mg PO / IV / IM ( ) q 4 hours ( ) q 8 hours PRN itch or insomnia
( ) Reglan 10 mg IV / PO q 6 hours PRN nausea
(X) Zofran 4 mg IV q 6 hours PRN nausea

ADDITIONAL ORDERS

( ) Sign and Witness Consent
(X) [illegible] be endorsed IV now
(X) [illegible] IV q day
(X) Decadron 4mg IV stat, first dose now

(b)(6)

PREPARED BY (Signature & Title): (b)(6)

Tripler Medical Support Hospital

DATE (yyyymmdd): 20080709

PATIENT'S IDENTIFICATION (Typed or written names given: Name (Last, First, Middle), Grade, Date, Hospital or Medical Facility)

PSUEDO ISN: (b)(6) ISN: _____

( ) HISTORY / PHYSICAL
( ) OTHER EXAMINATION
( ) DIAGNOSTIC STUDIES
( ) TREATMENT

( ) FLOW CHART
(X) OTHER (specify) *Provider Orders*

LOCATION: ( ) ICU ( ) ICW BED # _____ AGE _____

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EXHIBIT

ACLU DDII CID ROIS 37235

[illegible]		
[illegible]		
[illegible]		
3. PULMONARY: Respirations within normal rate for age group, quiet and regular depth is regular, no cough, lungs CTA bilateral with symmetrical chest movement.		
4. GI: Abdomen soft NT/ND, no S/S of guards, no N/V/D, constipation or rectal bleeding. No change in appetite or difficulty chewing or swallowing	( )	( )
5. GU/REPRODUCTIVE: No S/S of dysuria, retention, urgency, frequency or nocturia. Urine clear yellow / amber. No unusual vaginal / penile / breast discharge.	( )	( )
6. MUSCULOSKELETAL: Normal muscle development and mass for age, no deformities, no assistive devices needed. Normal ROM without pain, no joint swelling tenderness, weakness or paresthesia.	( )	( )
7. SKIN: Warm, dry, intact, turgor good, no rashes, inflammation, ulcers, breaks in skin, No redness, blanching, irritation over bony prominences, mucous membranes moist and intact.	( )	( )
8. PYSCHOSOCIAL: Behavior is appropriate to the situation, anxiety is controlled or mild and appropriate. Interacts appropriately with others.	( )	( )
9. PAIN: 0-10, location, description to include what makes it better and what makes it worse. If medication prescribed, document intervention and reassessment.	( )	( )

[illegible] (Signature / Title) | DEPARTMENT/SERVICE/CLINIC | [illegible]

[illegible] Hospital

[illegible] (Name, Grade, Date Hospital or Medical Facility)

( ) HISTORY / PHYSICAL
( ) OTHER EXAMINATION
( ) DIAGNOSTIC STUDIES
( ) TREATMENT

[illegible]
(X) OTHER (Specify)
ICW Reassessment

PSUEDO ISN (b)(6) ISN 37236

LOCATION [illegible] ICW BED # 2 AGE

MEDCOM FORM 4700 FEB 2000 Page 1 of 2 For Official Use Only Law Enforcement Only EXHIBIT (b)(6)

ACLU DDII CID ROIS 37236

0022-03-0378-5[illegible]

[illegible] Privacy Act of 1974 [illegible]
[illegible] HOSPITAL
[illegible] 13 [illegible]
[illegible] ARMPIA

[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
				BLOOD
[illegible] 0619 (COM)				
WBC	12.1	H	(4.8-10.8)	x10 3/uL
RBC CNT	3.61	L	(4.20-6.10)	x10 6/uL
HGB	11.7	L	(12.0-18.0)	g/dL
HCT	35.7	L	(42-52)	%
MCV	98.9		(80.0-99.0)	fl
MCH	32.3	H	(27.0-31.0)	pg
MCHC	32.7	L	(33.0-37.0)	g/dL
PLATELETS	263		(130-400)	x 10(3)/uL
LYMPH%	20	L	(20.0-44.0)	%
LYMPH#	2.4		(0.7-4.3)	x10 3/uL

*=Critical R=Resist S=Susc MS=Mod Susc I=Intermed
L=Lo H=Hi (O)rder, (I)nterpretations, (R)esult
Uncert /A=Amended Comments=

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EXHIBIT 3

ACLU DDII CID ROIS 37237

EXHIBIT

4 - Spoken
3 - To Sound
2 - To Pain
1 - None

Verbal Response:
5 - Oriented
4 - Confused
3 - Inappropriate Words
2 - Incomprehensible Sounds
1 - None (Note - "T" = tube)

Motor Response:
6 - Obey Commands
5 - Localizes to pain
4 - Withdraws to Pain
3 - Flexion to pain
2 - Extension to pain
1 - None

5 - Normal strength
4 - Less against resistance
3 - Moves against gravity
2 - Moves not against gravity
1 - No movement

Pupil Scale

2mm 3mm 4mm 5mm 6mm 7mm 8mm 9mm

RESTRAINTS:

0700 site	pulse	cap. ref.	edema	1900	Site	pulse	cap. ref.	edema
0900 site	pulse	cap. ref.	edema	2100	Site	pulse	cap. ref.	edema
1100 site	pulse	cap. ref.	edema	2300	Site	pulse	cap. ref.	edema
1300 site	pulse	cap. ref.	edema	0100	Site	pulse	cap. ref.	edema
1500 site	pulse	cap. ref.	edema	0300	Site	pulse	cap. ref.	edema
1700 site	pulse	cap. ref.	edema	0500	Site	pulse	cap.ref	edema

VASCULAR ACCESS

DEVICE/SITE	START DATE	DSG CHANGE	ASSESSMENT DAYS	ASSESSMENT EVENINGS	ASSESSMENT NIGHTS
(L) PIC [illegible]					
(L) femoral [illegible]	31 [illegible] 2008				P/CIT
(L) (R) 2CC	31 [illegible] 2008				CIDT
					CIDT

PREPARED BY: (signature & Title) | DEPARTMENT/SERVICE/CLINIC | DATE

PATIENT'S INDENTIFICATION

(b)(6)

☐ HISTORY/PHYSICAL
☐ OTHER EXAMINATION OR EVALUATION
☐ DIAGNOSTIC STUDIES
☐ TREATMENTS

☐ FLOWCHART
☐ OTHER

EXHIBIT

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[illegible]	
[illegible]	
Rhythm, Rate, [illegible] and selective	
Abnormal Heart Sounds – [illegible]	
murmur, gallop, click, rub), color,	
skin temp, JVD, Capillary refill,	
Pulses (strength, bilaterally), turgor,	
moisture, edema, carotid bruits/thrills,	
CVP, abnormal findings, Central lines	
(Location, appearance, dressing, etc.)	
RESPIRATORY	
Respiratory rate, rhythm, SaO2, oxygen	
delivery method, Ventilator settings,	
chest expansion, Accessory muscle use,	
lung sounds, cough, secretions/sputum	
(Color, amount, consistency) , ETT/Trach	
(size, placement, appearance), Chest	
Tubes (location, Suction/H20 seal, air	
leaks, drainage amount & color, dressing)	
Arterial line (appearance, location, etc.)	
GASTROINTESTINAL	
Oral cavity appearance, dentition,	
Mucosal appearance, odor, Abdomen	
(contour, distention, tenderness, soft,	
Firm, guarding, bowel sounds), NG/OG/	
G-Tube (placement, verified, residuals),	
Tube feeds (type, rate), suction, stool/	
Emesis (color/consistency/amount),	
Colostomy (stoma location & appearance)	
GENITOURINARY	
Mode of elimination (void, foley, urostomy),	
Foley size, bladder distention,	
Urine (color, amount, sediment)	
INTEGUMENTARY	
General skin condition, dressings	
(locations, condition), wounds, lacerations,	
Incisions (staples or sutures, approximation	
of wound edges, drainage, signs of	
infection), drains (JP, hemovacs, etc.),	
Drainage (color, amount), protective aids,	
Decubitus ulcers, IV sites (location, fluid,	
rate, appearance, dressing), any additional	
Skin findings	

EXHIBIT 2

Overall Fluid Status:
(Running Total Fluid balance)

Vol.										
Peep										
PS										
Pain Scale										
Pain Med										
Pt Position										
CVP										
(INTAKE) TIME	23	24	01	02	03	04	05	06	Total 8 HRS	24 HOUR TOTAL
IV										
IVPB										
PO/ TF										
Other										
TOTAL										

OUTPUT TIME	23	24	01	02	03	04	05	06	Total 8 HRS	24 HOUR TOTAL
Urine output /Total										
NG output										
Emesis										
Stool										
Chest tube #1/ #2										
Jackson Pratt #1/ #2										
TOTAL										

Name	Signature
(b)(6)	
EXHIBIT	

Legend

Init=initials
JVD=Jugular Venous Distention
L=Left
NIBP=Noninvasive Blood Pressure
N=No
Y= Yes
+2= strong +1=weak

P=Prone
R= Right
SaO2=Saturation of Arterial Oxygen
S= Supine
ABP= Arterial Blood Pressure
PS=Pharmacologically Sedated

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[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

3 – Inappropriate Words

2 – Incomprehensible Sounds

1 – None (Note – "T" = tube)

Motor Response:

6 – Obey Commands

5 – Localizes to pain

4 – Withdraws to Pain

3 – Flexion to pain

2 – Extension to pain

1 - None

Pupil Scale

2mm	3mm	4mm	5mm	6mm	7mm	8mm	9mm

RESTRAINTS:

0700 site	pulse	cap. ref.	edema	1900	Site	pulse	cap. ref	edema
0900 site	pulse	cap. ref.	edema	2100	Site	pulse	cap. ref.	edema
1100 site	pulse	cap. ref.	edema	2300	Site	pulse	cap. ref.	edema
1300 site	pulse	cap. ref.	edema	0100	Site	pulse	cap. ref.	edema
1500 site	pulse	cap. ref.	edema	0300	Site	pulse	cap. ref.	edema
1700 site	pulse	cap. ref.	edema	0500	Site	pulse	cap.ref	edema

VASCULAR ACCESS

DEVICE/SITE	START DATE	DSG CHANGE	ASSESSMENT DAYS	ASSESSMENT EVENINGS	ASSESSMENT NIGHTS
(L) Foot 22G	31 Jul 2005				
(L) Foot 20G	31 Jul 2005				

PREPARED BY: (signature & Title)	DEPARTMENT/SERVICE/CLINIC	DATE
(b)(6)		

PATIENT'S INDENTIFICATION

(b)(6)

☐ HISTORY/PHYSICAL
☐ OTHER EXAMINATION OR EVALUATION
☐ DIAGNOSTIC STUDIES

☐ FLOWCHART
☐ OTHER

EXHIBIT

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Dermatic, gallbp, [illegible]	
skin temp, JVD, Capillary refill,	
Pulses (strength, dilatability, bruits,	
moisture, edema, carotid bruits/thrills,	
CVP, abnormal findings, Central lines	
(Location, appearance, dressing, etc.)	
RESPIRATORY	
Respiratory rate, rhythm, SaO2, oxygen	
delivery method, Ventilator settings,	
chest expansion, Accessory muscle use,	
lung sounds, cough, secretions/sputum	
(Color, amount, consistency) , ETT/Trach	
(size, placement, appearance), Chest	
Tubes (location, Suction/H20 seal, air	
leaks, drainage amount & color, dressing)	
Arterial line (appearance, location, etc.)	
GASTROINTESTINAL	
Oral cavity appearance, dentition,	
Mucosal appearance, odor, Abdomen	
(contour, distention, tenderness, soft,	
Firm, guarding, bowel sounds), NG/OG/	
G-Tube (placement, verified, residuals),	
Tube feeds (type, rate), suction, stool/	
Emesis (color/consistency/amount),	
Colostomy (stoma location & appearance)	
GENITOURINARY	
Mode of elimination (void, foley, urostomy),	
Foley size, bladder distention,	
Urine (color, amount, sediment)	
INTEGUMENTARY	
General skin condition, dressings	
(locations, condition), wounds, lacerations,	
Incisions (staples or sutures, approximation	
of wound edges, drainage, signs of	
infection), drains (JP, hemovacs, etc.),	
Drainage (color, amount), protective aids,	
Decubitus ulcers, IV sites (location, fluid,	
rate, appearance, dressing), any additional	
Skin findings	

EXHIBIT 2

Overall Fluid Status
(Running Total Fluid balance)

Pulse										
RR										
SS										
Pain Scale										
Pain Med										
Pt Position										
CVP										
INTAKE TIME	23	24	01	02	03	04	05	06	Total 8 HRS	24 HOUR TOTAL
IV										
MTB										
PO/ TF										
Other										
TOTAL										

OUTPUT TIME	23	24	01	02	03	04	05	06	Total 8 HRS	24 HOUR TOTAL
Urine output /Total										
NG output										
Emesis										
Stool										
Chest tube #1/ #2										
Jackson Pratt #1/ #2										
TOTAL										

Name	Signature

Legend

Init=initials
JVD=Jugular Venous Distention
L=Left
NIBP=Noninvasive Blood Pressure
N=No
Y= Yes

P=Prone
R= Right
SaO2=Saturation of Arterial Oxygen
S= Supine
ABP= Arterial Blood Pressure
PS=Pharmacologically Sedated

EXHIBIT 2

CONSULT WITH	TIME	ACTION

REGARDS

(1) metastatic lung CA

(2) pneumonia

PATIENT'S IDENTIFICATION

(b)(6)

I have reviewed and understand these instructions

PATIENT'S SIGNATURE

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EXHIBIT

ACLU DDII CID ROIS 37245

EMERGENCY

CATEGORY OF TREATMENT

ORDERS

MEDICATIONS | DOSE | ROUTE | TIME | INT | RECORD

IV SITE | SIZE | TIME | INT

VITAL SIGNS

TIME					
BP					
PULSE					
RESP					
TEMP					
SpO2					
PAIN					

MEDIC NOTE

MED HX

SURG HX

SOCIAL HX

(b)(6)

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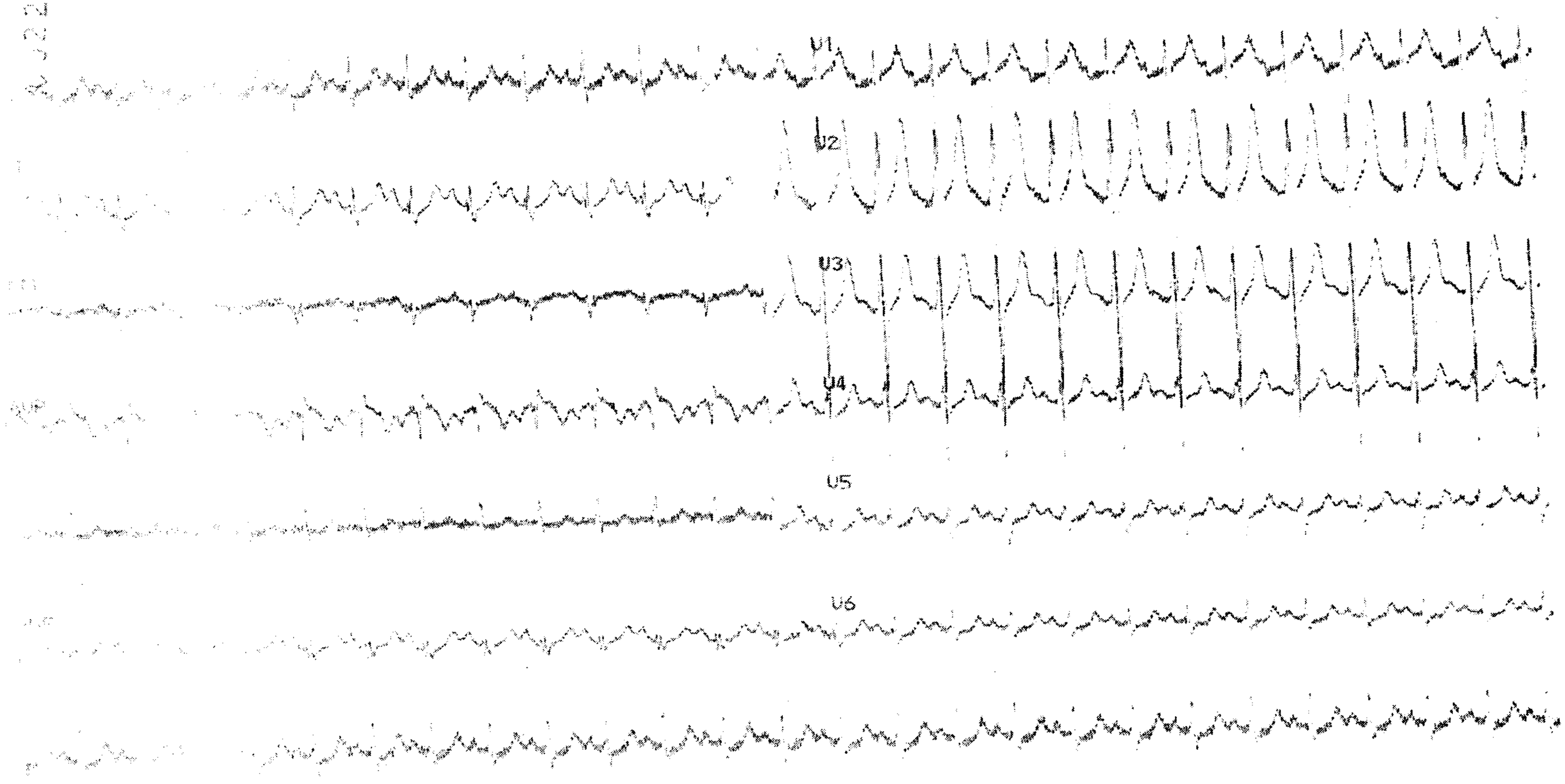
ACLU DDII CID ROIS 37246

HR 157 bpm

Interpretation:

Unconfirmed report.



25mm/s 10mm/mV AOS 50Hz 0.08 - 150Hz 6_F1_P Automatic V6.2 (1)

EXHIBIT

ACLU DDII CID ROIS 37247

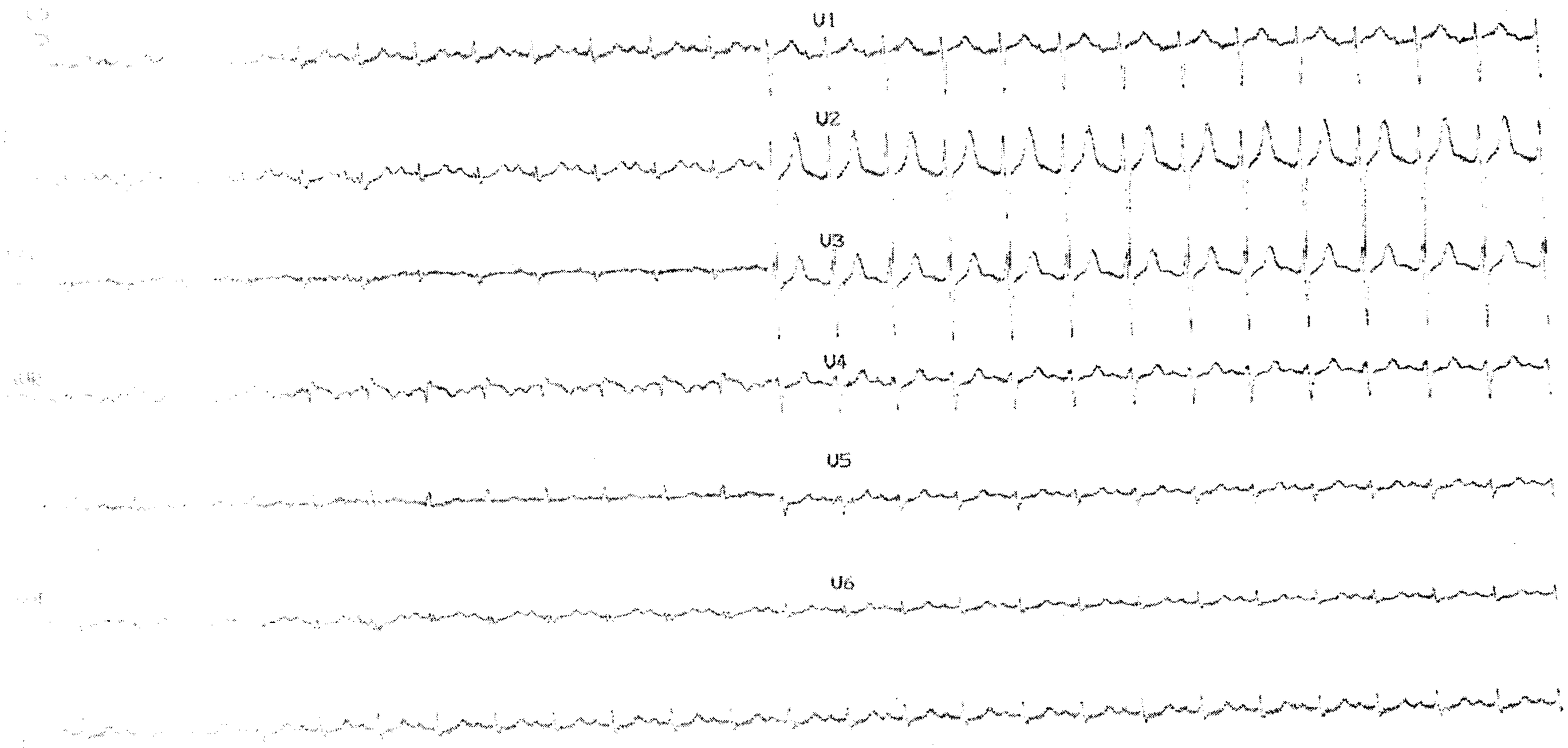
000037

ACLU-RDI 5590 p.38

HR 157 bpm

Interpretation:

Unconfirmed report.



25mm/s 5mm/mV ADS 50Hz 0.08 - 150Hz 6_F1_R Automatic U6.2 (1)

EXHIBIT

Law Enforcement Sensitive

ACLU DDII CID ROIS 37248

000038

ACLU-RDI 5590 p.39

MEDICAL RECORD

PROGRESS NOTES

ACTIVE DUTY MILITARY PERS

-CID 789-5520

DATE

NOTES

ED physician

Asked to evaluate pt in Radiology. Pt is [illegible] to know probable [illegible] prior to [illegible] he was expected to have a [illegible] [illegible], then [illegible] [illegible] to [illegible] [illegible]. [illegible] was reviewed. He is known to have terminal [illegible]. Please see

(b)(6)

note. On exam, I find pt [illegible] in [illegible], RR [illegible], BP [illegible], HR [illegible]. Heart – (B) [illegible] [illegible], (L) [illegible] [illegible], Rightward [illegible] [illegible] [illegible] [illegible] [illegible] – [illegible] [illegible] [illegible] [illegible] [illegible]

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
[illegible]	[illegible]
[illegible]	[illegible]
	(b)(6)
8 July 05 1233	Pt accompanied from ICU. [illegible]
	[illegible] (b)(6)
	[illegible]
	(b)(6)
	[illegible]
	(b)(6)

MEDICAL RECORD

PROGRESS NOTES 322-08-CID789-55207

(b)(6)

(b)(6)

(b)(6)

(b)(6)

(b)(6)

(b)(6)

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
	LAST	FIRST	MI	
DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT		
PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)		REGISTER NO.	WARD NO.	

(b)(6)

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. [illegible])
Prescribed by OSAD MR [illegible]

For Official Use
Law Enforcement [illegible]

ACLU DDII CID ROIS 37251

0022-08-CID789-93767

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE

(b)(6)

(b)(6)

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EXHIBIT

ACLU DDII CID ROIS 37252

(b)(6)

(b)(6)

(b)(6)

(b)(6)

(b)(6)

1 Growth and Development
2 Neurological
a) Orientation
b) Level of Consciousness: alert, drowsy, lethargic, comatose, decerebrate, responds to stimuli and painful stimuli, responds to follow commands, reflexes
c) Describe abnormalities
3 E.N.T., Eyes, Ears, and Throat
a) Eyes: Pupils, vision
b) Ears: Hearing, drainage
c) Mouth: Dentition, lesions, gingivitis
d) Throat: Size, tonsils, lesions, swallowing, difficulty, voice, hoarseness, stridor, drooling
4 Cardiovascular
a) Heart sounds: regular, irregular, murmurs
b) Peripheral Circulation: Pulses, edema, extremities
c) IV's: Catheters at bedside (tangue), bedside monitor, condition of site
d) [illegible]
e) Intrathoracic tubes and/or dressing
5 Pulmonary
a) Respirations: Pain, regularity, effortlessness, depth, use of accessory muscles, paternal/external dyspnea: Chest movement associated with respirations
b) Breath sounds: Clear to auscultation, Rales, Rhonchi, Wheezes, [illegible]
c) Oxygen: Percent given, liters/min, method of administration, comments or [illegible]
[illegible]
6 Genitourinary
a) Urination: Continence, pattern change
[illegible] Vaginal Discharge, Last PAP smear (if applicable)
c) Male: Abnormal discharge, swelling, pain
8. Integumentary
a) Lesions, pressure points, contractures
b) Color, moisture, edema, [illegible] changes in pigmentation
9 Musculoskeletal
a) Movement (range of motion, purposeful, [illegible] level of gait activity
b) [illegible]
10 [illegible]
a) [illegible]
[illegible]

REFERENCES: [illegible]
AMPEX [illegible]

DA FORM 3588, FEB 2003

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EXHIBIT

4. Do you have any other medical problems?	☐	☐
5. Have you been recently hospitalized? If so, when and for what?	☐	☐
6. What medications have you been taking? (to include prescription and over-the-counter drugs) For how long?	☐	☐
7. Are you allergic to anything? If so, what? What reaction?	☐	☐
8. Do you have any special needs that require assistance with daily activities? (e.g. diet, eating, bathing, elimination, ambulating, sleeping.) Prosthetics: dentures, reading glasses, contacts	☐	☐
9. What other concerns do you have?		
10. How can we be most helpful?		

11. Name of Local Contact/NOK	12. Relationship	13. Telephone Num.
14. Interviewer's Signature, Rank & Title. (b)(6)	15. Informant/Relationship	
16. Patient Identification	17. Personal Articles and Vital Signs (Indicate if not done by medic.) Item / Indicator / Sign / Location	

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EXHIBIT

ACLU DDII CID ROIS 37254

0022-06-CID789-53207

DA FORM 4677, 1 OCT 1976

EXHIBIT

ACLU DDII CID ROIS 37255

THERAPEUTIC DOCUMENTATION CARE PLAN

NON-MEDICATION

SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
[illegible]	[illegible]	[illegible]	[illegible]	(b)(6)
[illegible]				
[illegible]				

Check Rules	PRN ACTION FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED

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EXHIBIT C

ACLU DDII CID ROIS 37256

NURSE'S RECORD — DOCUMENTATION CARE PLAN

The proponent agency is the Office of The Surg

ORDER DATE	CLERIC NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR
	(b)(6)		
			D (b)(6)
		Vital Signs Q Shift	06 (b)(6)
			14
			22
			D
			N
			06
			14
			22
			D
			N

(b)(6)

ALLERGIES ☐ YES ☑ NO

NKDA

PRIMARY DIAGNOSIS

Pneumonia, [illegible]

ADDITIONAL PAGES IN USE ☐ YES ☐ NO

PAGE NO:

PATIENT IDENTIFICATION:

(b)(6)

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

D 08 09 10 11 12 13 14 15

E 16 17 18 19 20 21 22 23

N 24 01 02 03 04 05 06 07

DA FORM 4677, 1 OCT 1978 EDITION OF 1 DEC 77 MAY BE USED

EXHIBIT

ACLU DDII CID ROIS 37257

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo 10 Yr 2007

Verify by Initialing: Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
	(b)(6)	[illegible]				(b)(6)
		[illegible]				
		[illegible]				
		LABS				
[illegible]		CBC, CMP	30 Jul 07	0500	0500	
[illegible]		Place [illegible]	[illegible]	[illegible]	925	
[illegible]		PA lat CXR x 1 [illegible]	[illegible]	[illegible]	[illegible]	
[illegible]		Transfer [illegible]	[illegible]	[illegible]	[illegible]	

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION — TIME/DATE COMPLETED
		Call HO for Temp	

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EXHIBIT 9

0022-06-003789-53207

ORDER DATE | CLERK NURSE | DESCRIBING MEDICATIONS DOSE, FREQUENCY | HRS | DATE DISPENSED

(b)(6)

(b)(6)

(b)(6)

(b)(6)

(b)(6)

ALLERGIES ☐ YES ☐ NO | PRIMARY DIAGNOSIS

ADDITIONAL PAGES IN USE ☐ YES ☐ NO

USE PENCIL. CIRCLE MLD TIMES

D 7 8 9 10 11 12 13 14

E 15 16 17 18 19 20 21 22

N 23 24 01 02 03 04 05 06

EXHIBIT 2

04 FORM 4676, 1 FEB 79

ACLU DDII CID ROIS 37259

Verify by Initialing						
Order Date	Clerk/ Nurse					
	(b)(6)					(b)(6)

Order Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION TIME/DATE DISPENSED											
30 July 2003	(b)(6)	Zofran 4mg IV q 8 hr for Nausea												

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EXHIBIT 6

PSYCHOTHERAPY DOCUMENTATION CARE PLAN

ORDER DATE | TIME/INITIALS | RECURRING MEDICATION/TREATMENT

DATE DISPENSED

(b)(6)

(b)(6)

(b)(6)

(b)(6)

ADDITIONAL PAGES IN USE

YES NO

PAGE NO

PRELIMINARY DIAGNOSIS

Schizophrenia, Paranoid Type

DA FORM 4678, 1 FEB 79

EXHIBIT

ACLU DDII CID ROIS 37261

Order Date	Clerk/ Nurse	SUB-ORDER REQUIREMENTS			
	(b)(6)				

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION TIME/DATE DISPENSED					
	(b)(6)							

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4. [illegible] pruritis, no HFGD, [illegible] rectal bleeding. No change in appetite or difficulty cleaning or swallowing.

5. GENITO-REPRODUCTIVE: No GU or dysuria, retention, urgency, frequency or incontinence. Urine clear yellow / amber. No unusual vaginal / penile / breast discharge.

6. MUSCULOSKELETAL: Normal muscle development and muscle bulk, no deformities, no assistive devices needed. Normal ROM without pain, no joint swelling, tenderness, weakness or paresthesia.

7. SKIN: Warm, dry, intact, turgor good, no rashes, inflammation, pieces, breaks in skin. No redness, blanching, irritation over bony prominences, mucous membranes moist and intact.

8. PSYCHOSOCIAL: Behaviors appropriate to the situation, anxiety is controlled or mild and appropriate. Interacts appropriately with others.

(b)(6)

EXHIBIT

ACLU DDII CID ROIS 37263

MEDICAL GROUP - SUPPLEMENTAL MEDICAL [illegible]

ICW REASSESSMENT Continuation

DATE: 30 July 03

Time: [illegible] Initials: (b)(6)

Time: Initials:

Location:

Infected/Infiltrated:

Date To Change:

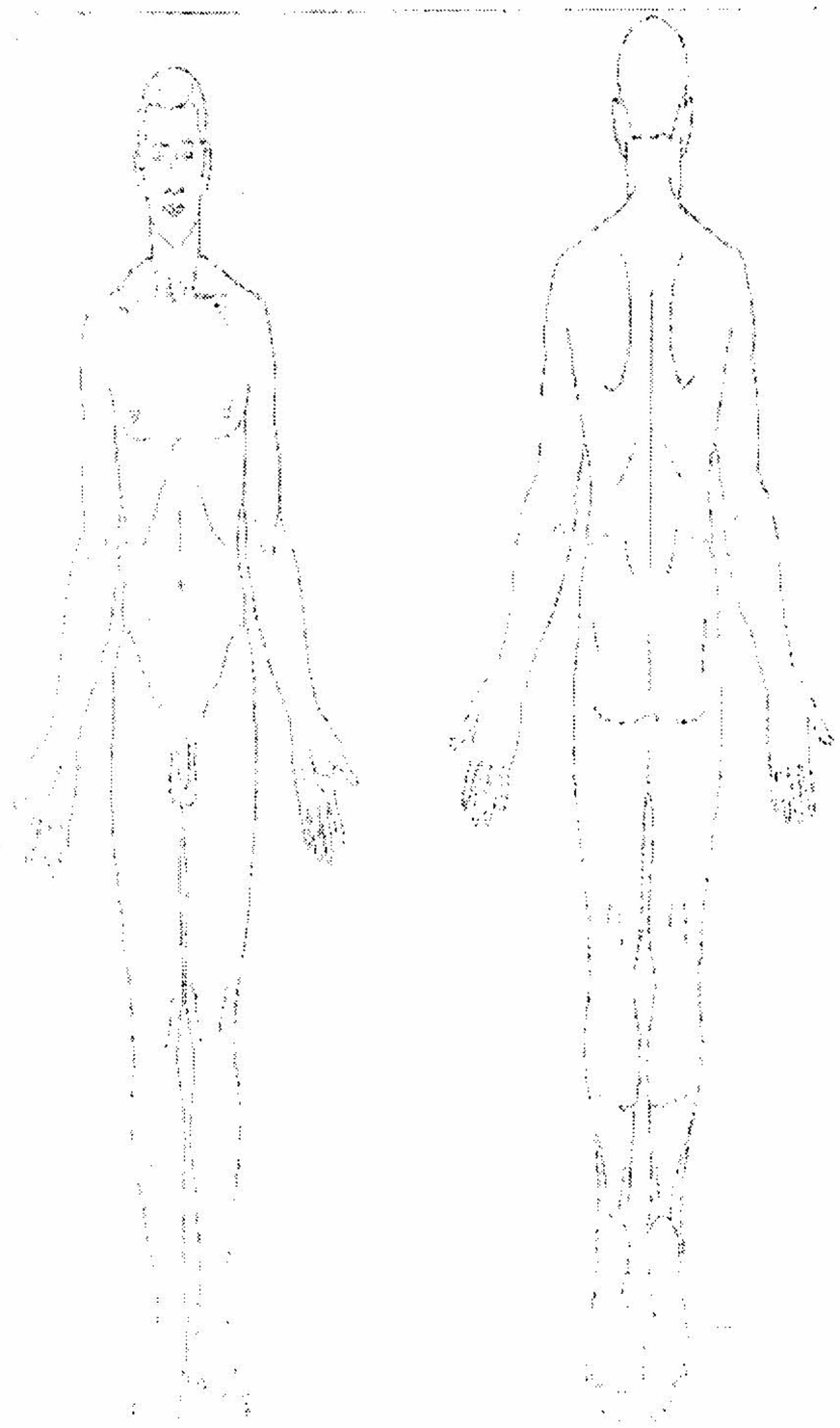
Fluid / Rate:

Location:

Not Infected/Infiltrated:

Date To Change:

Fluid / Rate:



(b)(6)

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EXHIBIT 8

ACLU DDII CID ROIS 37264

SUPPLEMENTAL MEDICAL DATA

INITIAL ASSESSMENT

CIRCLE ALL THAT APPLY

1. NEUROLOGICAL

LOC: Alert & Oriented: Person Place Time Level (specify) (R) drop (L) drop GCS 1-6

Responds to: Verbal Tactile Painful Unresponsive Communicates needs

Pupil size: (R) mm (L) mm Sclerotic

Reaction to light: Brisk Sluggish Non-reactive

1mm 3mm 4mm 5mm 6mm 7mm 8mm

2. Cardiovascular

Arrhythmia Bradycardia Asystole Cardiac Monitor

Heart Sounds: Normal S1 S2 Irregular Distant Abnormal S3 S4 Murmur Gallop Click Rub Pacemaker (type)

Pulses: 0 (absent) 1+ (thready) 2+ (weak) 3+ (normal) 4+ (bounding) JVD Carotid Bruits/Thrills

Edema: 0 (none) 1+ (trace) 2+ (moderate) 3+ (deep) 4+ (very deep) Location: Pitting / Non Pitting

Cap Refill < 3 sec: R Upper R Lower L Upper L Lower

Mucous membranes: Pink Pale Cyanotic

3. PULMONARY

Symmetrical Movement Regular Rate/Depth Accessory muscle use O2 Liters via NC Mask NRB

Shortness of breath Orthopnea Dyspnea Night Sweats Tracheotomy Size Type Trach Mask

Cough: None Non-productive Sputum: Clear White Yellow Green Hemoptysis PE confirmed

Lungs: CTA Bilaterally Wheezes Rhonchi Rales Location: RUL RML RLL LUL LLL

4. G.I.

Abdomen: Flat Round Distention Soft Firm Rigid Non-tender Tender Painful Guarding Present

Bowel Sounds Absent Hypoactive Normoactive Hyperactive Location: (quadrants) RUQ RLQ LUQ LLQ

Flatus Heartburn Hemorrhoids Rectal Bleeding LBM Colostomy Location Appearance

Stool (describe) G Tube NGT OG Suction Placement Verified via Air Bolus Residuals

Oral mucosa: Moist No Lesions Lesions Leukoplakia Aphthae Normal Decreased Diet Regular Clears NPO Special

Swallow and Gag Intact Absent Nausea Emesis (describe): Tube Feeding Type Rate

5. G.U.

Voids: Urinal BR Incontinent Foley Size Suprapubic Dysuria Retention Urgency Frequency Nocturia

Urine Clear Concentrated Cloudy Yellow Amber Tea Colored Blood Tinged Sediment

Vaginal/Penile Lesions Urethral Discharge: Breast/Testicular Lumps

6. MUSCULOSKELETAL

Normal muscle development and mass for age No deformities

Amputations BKA AKA Finger Toe Arm Right Left Weakness Paralysis

Ambulatory Gait Steady Unable Assistive Devices:

Joints Stiffness Swelling Tender Painful with ROM Hx of DVT

Muscle Strength R Upper R Lower L Upper L Lower

0 (no movement) 2+ (moves but NOT against gravity) 4+ (moves against resistance)

1+ (trace movement) 3+ (moves against gravity) 5+ (normal strength)

7. INTEGUMENTARY

Color: Alert Pale Flushed Cyanotic Jaundiced Mottled IV Size Location

Moist Dehydrated Warm Cool Turgor Good Fair Poor Bleeding Location

Bruises Location Rashes Location Abrasions Location Burns Location

Lacerations Location Infections Location Decubitus Location Ulcers Location

PHYSICIAN (Signature) PHYSICIAN'S NAME/CLINIC DATE (YYYYMMDD)

Unit, Marks, Grade, Units Hospital or Medical Facility)

PSEUDO ISN (b)(6) ISN

LOCATION AGE

( ) HISTORY / PHYSICAL
( ) OTHER EXAMINATION
( ) DIAGNOSTIC STUDIES
( ) TREATMENT

( ) FLOW CHART
(X) OTHER (specify)
ICW Initial Assessment

EXHIBIT 8

MEDCOM FORM 4700 FEB 2003 PAGE 1 OF 2 21 CSP CP 08-03 (25 Jan 08)

REPORT TITLE

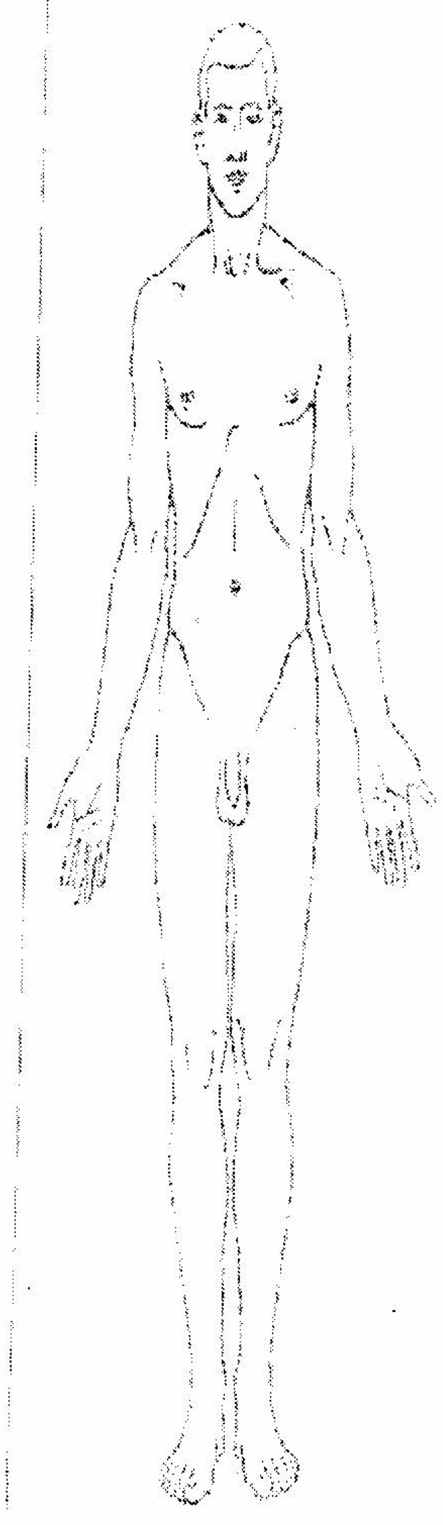
ICW INITIAL ASSESSMENT Continuation

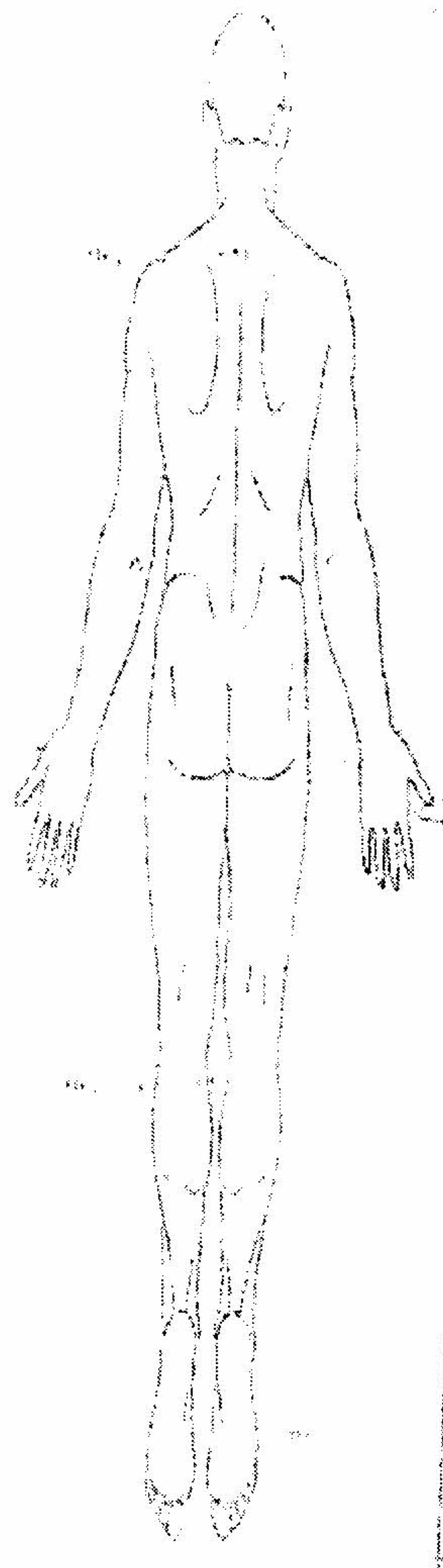
OTSG APPROVED (Date)

DATE 30 Jul 08

8. PSYCHOSOCIAL

9. PAIN





(b)(6)

(b)(6)

PREPARED BY (Signature & Title)
31st Combat Support Hospital

DEPARTMENT/ SERVICE/ CLINIC
DCCS

DATE (yyyymmdd)

( ) HISTORY / PHYSICAL
( ) OTHER EXAMINATION
( ) DIAGNOSTIC STUDIES
( ) PROCEDURE

( ) FLOW CHART
(X) OTHER (specify)
ICW Initial Assessment

MEDCOM FORM 4790, 1 OCT 2002, Page 1 of 2

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EXHIBIT 9

ACLU DDII CID ROIS 37266

0022 CID789 53207
TAI

CERTIFICATE OF DEATH

For use of this form, see AR 190-8; the proponent agency is PMG.

INTERNMENT SERIAL NUMBER

FROM:

TO:

NAME (Last, first, MI) | GRADE | SERVICE NUMBER

NATIONALITY | POWER SERVED | PLACE OF CAPTURE/INTERNMENT AND DATE

PLACE OF BIRTH | DATE OF BIRTH

NAME, ADDRESS, AND RELATIONSHIP OF NEXT OF KIN | FIRST NAME OF FATHER

PLACE OF DEATH: Baghdad-Camp Cropper, Iraq | DATE OF DEATH: 31 July 2008 | CAUSE OF DEATH: Lung Cancer with brain metastasis

PLACE OF BURIAL | DATE OF BURIAL

IDENTIFICATION OF GRAVE

PERSONAL EFFECTS *(To be filled in by Office of Deputy Chief of Staff for Personnel)*

___ RETAINED BY DETAINING POWER ___ FORWARDED WITH DEATH CERTIFICATE TO *(Specify)* ___ FORWARDED SEPARATELY TO *(Specify)*

BRIEF DETAILS OF DEATH. BURIAL BY PERSON WHO CARED FOR THE DECEASED DURING ILLNESS OR DURING LAST MOMENTS *(Doctor, Nurse, Minister of Religion, Fellow Internee)*. IF CREMATED, GIVE REASON. *(If more space is required, continue on reverse side).*

Patient admitted for malaise, weakness, cough, headache. He was diagnosed with pneumonia and placed on antibiotics. By day #2 patient began to become more drowsy and by the evening of day #2, the patient was non-responsive. On the am of day #3, he had fixed and dilated pupils, and was pronounced dead by mid afternoon.

DO NOT WRITE IN THIS SPACE
CERTIFIED A TRUE COPY

DATE: 31 July 08

SIGNATURE OF MEDICAL OFFICER: (b)(6)

SIGNATURE OF COMMANDING OFF

WITNESSES

SIGNATURE | ADDRESS

SIGNATURE | ADDRESS

DA FORM 2669-R, MAY 82 EDITION OF 1 JUL 63 IS OBSOLETE. APD V1.00

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LAW ENFORCEMENT SENSITIVE

ACLU DDII CID ROI 87267

EXHIBIT 3

AGENT'S INVESTIGATION REPORT

CID Regulation 195-1

ROI NUMBER 0022-08-CID789-53207

DETAILS

EXAMINATION OF REMAINS: About 1700, 31 Jul 08, SA (b)(6), (b)(7)(C) conducted an examination of the remains of Mr. HASAN while at Bed 8, ICU, 115th CSH.

Characteristics of Remains: The decedent was identified, via retinal scan, as Mr. HASAN. The decedent appeared to be a Middle Eastern male, approximately 5'6", and weighed 103 pounds. The decedent had black/gray "peppered" hair and brown eyes. No tattoos were visible. The decedent was clothed with a hospital gown and white cotton boxer shorts, and covered with a bed sheet. Evidence of medical intervention included an intravenous lead in the left foot, a catheter inserted into the penis, numerous leads around the midsection, and healing wounds in both arms from intravenous leads.

Conditions of Remains: The remains were warm to the touch, and rigor mortis was not present. Minor amounts of livor mortis was noted on the back of the decedent. No signs of external trauma, except for signs of medical intervention, were observed. The decedent was not wearing any jewelry.

Environmental Conditions: At the time of the examination, the temperature inside the ICU was 68 degrees. There were no odors out of the ordinary near the remains during the time of the examination.

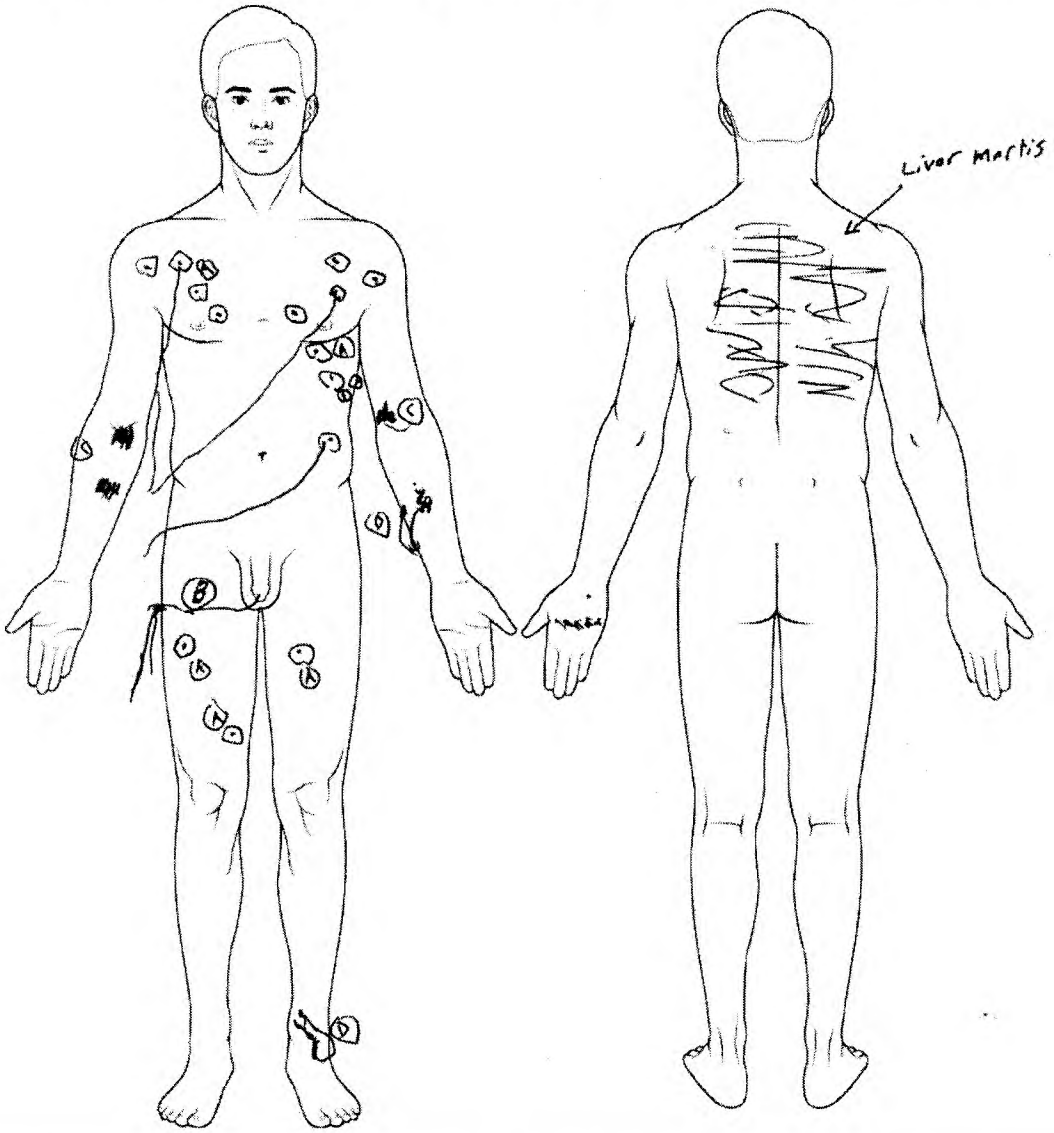
Documentation of Remains: The remains were documented by SA (b)(6), (b)(7)(C) utilizing a NIKON Coolpix 5900 Camera with a built in flash. A human remains sketch was prepared by SA (b)(6), (b)(7)(C)

Collection of Evidence: A collection of evidence was not performed due to the fact that the remains were located at the ICU for three days prior to his demise, and all clothing was disposed of by hospital staff.
///Last Entry///

TYPED AGENT'S NAME AND SEQUENCE NUMBER	ORGANIZATION
For SA (b)(6), (b)(7)(C), (b)(7)(F)	Camp Cropper CID Office, 1149th/20th MP DET (CID) Camp Cropper, Baghdad, Iraq APO AE 09342
SIGNATURE (b)(6), (b)(7)(C)	DATE 31 Jul 08 / EXHIBIT 4

CID FORM 94
(Automated)

Rough Sketch Depicting Human Remains



LEGEND	TITLE BLOCK:
A: Leads	Case#: 0022-08-CID 789-53207
B: Intravenous tube	Offense: undetermined Manner of Death
C: Bruising from IV's	Person Portrayed: Mr. Mahmud Rashid HASAN
D: IV's tubes	Location: Trauma Care Unit, 115th CSH Camp Cropper, IZ APO AE 09342
E:	Victim: Mr. Mahmud Rashid HASAN
F:	Date/Time: 1700 / 31 JUL 08
G:	Sketched By: SA (b)(6), (b)(7)(C), (b)(7)(F) [redacted]
H:	Verified By:
I:	

EXHIBIT 5

AGENT'S INVESTIGATION REPORT	ROI NUMBER (0166-08-CID112) 0022-08-CID789-53207
CID Regulation 195-1	PAGE 1 OF 1 PAGES

DETAILS

BASIS FOR INVESTIGATION: On 4 Aug 08, this office received a Request for Assistance (RFA) from the Camp Cropper CID Office, Camp Cropper, Iraq (IZ) APO AE 09342. The RFA requested this office to attend the autopsy of Mr. Mahmud R. HASAN, Internment Serial Number US9IZ-315224-CI.

About 0800, 5 Aug 08, the autopsy of Mr. HASAN (ME# 08-0600), was attended by SA [redacted] (b)(6), (b)(7)(C) and SA [redacted] (b)(6), (b)(7)(C) both from the Fort Myer CID Office, Fort Myer, VA 22211. The autopsy was performed by Dr. [redacted] (b)(6), (b)(7)(C) Office of the Armed Forces Medical Examiner (OAFME), Armed Forces Institute of Pathology (AFIP), 1413 Research Blvd., Bldg 102, Rockville, MD, 20850. The preliminary cause of death and manner of death are pending. Photographers from AFIP exposed all digital photographs of the autopsy and prepared a compact disc (CD) containing all images exposed. SA [redacted] (b)(6), (b)(7)(C) obtained the fingerprints of Mr. HASAN and a copy of the CD containing all images was obtained. (See fingerprints and CD for details.)

Agent's Comment: The official results of the autopsy will be documented in the Final Autopsy Report which will be provided upon completion.

STATUS: This investigation is closed in the files of this office. No further investigative activity is anticipated or requested. ///LAST ENTRY///

TYPED AGENT'S NAME AND SEQUENCE NUMBER	ORGANIZATION	
(b)(6), (b)(7)(C), (b)(7)(F) [redacted] (b)(6), (b)(7)(C) [redacted]	Fort Myer CID Office Fort Myer, VA 22211	
	DATE 5 AUG 08	EXHIBIT 6

CID FORM 94
1 FEB 77

[redacted]

AGENT'S INVESTIGATION REPORT

CID Regulation 195-1

ROI NUMBER 0022-08-CID789-53207

PAGE 1 OF 1 PAGE

DETAILS

About 1640, 25 Sep 08, SA [redacted] (b)(6), (b)(7)(C) coordinated with Patient Administration Department and obtained all medical records of Mr. HASAN dated back to 4 Jun 07. Also collected was a Memorandum For Record which documented the findings of an Ethics Consultation conducted 31 Jul 08, which recommended Mr. HASAN receive only comfort care and his body be released to next of kin immediately following his death. A review of all records pertaining to Mr. HASAN revealed he was captured 20 May 07 for involvement with IED and VBIED emplacement, weapons facilitation, mortar attacks and possible Al-Qaida involvement. A chest X-Ray conducted 4 Jun 07 revealed a mass that was most overall compatible with primary lung carcinoma. On 14 Jun 07, Mr. HASAN was diagnosed with cancer and informed of the medical findings. On this date, a request was made by medical staff for a Compassionate Release from custody. On 15 Apr 08, it was documented that Mr. HASAN had a malignant brain tumor.

About 1000, 29 Sep 08, SA [redacted] (b)(6), (b)(7)(C) coordinated with SSG [redacted] (b)(6), (b)(7)(C) 111th QM CO, Mortuary Affairs, BIAP, Camp Sather, Iraq, who provided the Convoy List of Remains of Deceased Personnel, 20 Aug 08, and the Receipt of Remains by the Next of Kin, 20 Aug 08.

About 1100, 29 Sep 08, SA [redacted] (b)(6), (b)(7)(C) coordinated with Dr. (COL) [redacted] (b)(6), (b)(7)(C) 115th CSH, who stated Mr. HASAN was diagnosed with lung cancer during his initial capture screening. Dr. [redacted] (b)(6), (b)(7)(C) stated Mr. HASAN received comfort care and was provide medication to ease the pain associated with his condition. Mr. HASAN's cancer rapidly progressed to his brain, which caused tremendous swelling to his brain, and on 31 Jul 08, an ethics consultation was held in which it was decided Mr. HASAN's prognosis was terminal and that Compassionate Release would be requested. Dr. [redacted] (b)(6), (b)(7)(C) stated Mr. HASAN's condition progressed quicker than the process to approve a Compassionate Release, and on 31 July 08, he succumbed to Cancer. ///Last Entry///

TYPED AGENT'S NAME AND SEQUENCE NUMBER	ORGANIZATION	
SA [redacted] (b)(6), (b)(7)(C), (b)(7)(F)	24th/348th Military Police Detachment (CID)(FWD) Camp Cropper, Baghdad, Iraq APO AE 09342	
SIGNATURE [redacted] (b)(6), (b)(7)(C)	DATE 29 Sep 08	EXHIBIT 7

CID FORM 94 (Automated)

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Exhibit(s) 8 thru 13

Page(s) 000062 thru 000182 referred to:

CDR U.S. Army Medical Command
Freedom of Information/Privacy Act Office
ATTN: MCFP Bldg 126 Stop 76
1216 Stanley Road 2nd Floor
Fort Sam Houston, TX 78234-5049

0022 - [illegible] - 53207

Patient: CROP, ISN315224
Facility: TF 115th CSH (NORTH) (WBH6A1)

Date: 29 Jul 2008 2259 GST
Clinic: CROPPER HOSPITAL

Appt Type: ROUTN
Provider: (b)(6)

AutoCites Refreshed by @ 30 Jul 2008 0803 GST
Problems
visit for: administrative purpose
LUNG NEOPLASM MALIGNANT
BRAIN TUMOR MALIGNANT
METASTASIS TO BRAIN
PAPILLEDEMA ASSOCIATED WITH INCREASED INTRACRANIAL PRESSURE
REFRACTIVE ERROR - HYPERMETROPIA
LUNG CANCER
insomnia
SORE THROAT

Active Medications
No Active Medications Found.
Allergies
Patient has no known allergies

Screening Written by (b)(6) @ 29 Jul 2008 2259 GST

Appointment Reason For Visit: CHEST PAIN;

Selected Reason(s) For Visit:
CHEST PAIN (New) Comments:

Vitals Written by (b)(6) @ 30 Jul 2008 0359 GST
BP: 128/83, HR: 88, RR: 14, T: 97.5 °F, O2: 95, Tobacco Use: No, Alcohol Use: No, Pain Scale: 4/10 Moderate, Pain Scale Comments: body aches
Comments: Pt presents to the ER via vanguard with complaints of body aches x 3 days. Pt states he has experienced difficulty walking. C/O cough, fever, nausea, fatigue, and a decrease in appetite. Pt states he has a lung cancer. Denies any other symptoms.

S/O Note Written by (b)(6) @ 30 Jul 2008 0416 GST

History of present illness
The Patient is a 32 year old male.
° Encounter Background Information: Patient with known RUL lung CA with metastatic disease to brain. He is currently on Decadron therapy. He presents to CSH EMT after requesting medics for malaise, weakness, decrease appetite, fevers, cough, and nausea. He denies headaches. He states minimal PO intake today. he also complains of general body aches and trouble walking.
Past medical/surgical history
Reported History:
Past medical history lung CA with metastatic dx to brain.
Personal history
Social history heavy smoking history.
Review of systems
Systemic symptoms: Systemic symptoms malaise, body aches, fevers, chills, weakness.
Head symptoms: No head symptoms.
Otolaryngeal symptoms: No otolaryngeal symptoms.
Neck symptoms: Neck symptoms.
Cardiovascular symptoms: No cardiovascular symptoms.
Pulmonary symptoms: Pulmonary symptoms complains of cough and mild SOB.
Gastrointestinal symptoms: Gastrointestinal symptoms complains of nausea, no vomiting, no abdominal pain.

Name:CROP, ISN315224

		Sex:	M	Sponsor:	CROP, ISN315224
FMP/SSN:	20/900315224	Tel H:		Rank:	
DOB:	04 Jul 1976	Tel W:		Unit:	
PCat:	K78 FOREIGN NATIONAL-POW/INTERNEE	CS:		Outpt Rec. Rm:	
MC Status:		WS:		PCM:	
Insurance:	No			Tel. PCM:	

EXHIBIT 8

0022-9-[illegible]-53207

Skin symptoms: No skin symptoms.
Musculoskeletal symptoms: No musculoskeletal symptoms.

Physical findings

General appearance:
- General appearance: ill apearing male, no acute distress.

Eyes:
General/bilateral:
- Eyes: non icteric.

Ears, Nose, Throat:
- ENT: dry mucous membranes are present, OP clear,

Ears:
General/bilateral:
- Ears: normal.

Nose:
- Normal.

Neck:
- Neck: • Thyroid was diffusely enlarged. ° Thyroid was not tender.

Lungs:
- Lungs: diminished lung sounds bilaterally.

Cardiovascular system:
- Normal.

Back:
- Normal.

Abdomen:
- Abdomen: hepatomegaly is noted, possib;e mid abdominal mass noted.

Skin:
- Normal.

Musculoskeletal system:
General/bilateral: ° Musculoskeletal system: normal.

Tests

Laboratory studies:
Laboratory studies WBC 12.8, Hb 11.5, plt 280, Chem 8 nml.

Imaging studies:
Imaging studies CXR, RUL mass, diffuse bilateral lower lobe infiltrates, pneumonia versus mets, poor insp effort.

Assessment

- Diagnoses, syndromes and conditions 1. lung CA metastatic to brain 2. weakness and malaise, consider anemia, infection, electrolyte disurbance, increaseing tumor burden. 3 diffuse body aches, most likely secondary to #1

Therapy

- Therapy CBC, BMP, LFT's, thyroid panel, IV hydration, IV morphine for pain control. CXR reveals bilateral infiltrates. Patient given avelox 400 mg IV, placed on O2. He appears weak and will admit for observation, hydration, and abx.

A/P Written by (b)(6) @ 30 Jul 2008 0418 GST
1. LUNG CANCER
Comments:
2. PNEUMONIA
Comments:

Disposition Written by (b)(6) @ 30 Jul 2008 0418 GST
Admitted
Injury & Illness: Not Work Related; Not Battle Related; Category: All Other, Medical/Surgical Cause: Non-Battle Illness
Appointment Class: Outpatient
E&M Code: 99213 - Estab Outpatient Expanded H&P - Low Complexity Decisions

Signed By (b)(6) @ 30 Jul 2008 0803 GST
(b)(6)

Name:CROP, ISN315224

		Sex:	M	Sponsor:	CROP, ISN315224
FMP/SSN:	20/900315224	Tel H:		Rank:	
DOB:	04 Jul 1976	Tel W:		Unit:	
PCat:	K78 FOREIGN NATIONAL-POW/INTERNEE	CS:		Outpt Rec. Rm:	
MC Status:		WS:		PCM:	
Insurance:	No			Tel. PCM:	

TF 115th CSH (NORTH) (WBH6A1)

0022-08-CID789-53207

Name:CROP, ISN315224

		Sex:	M	Sponsor:	CROP, ISN315224
FMP/SSN:	20/900315224	Tel H:		Rank:	
DOB:	04 Jul 1976	Tel W:		Unit:	
PCat:	K78 FOREIGN NATIONAL-POW/INTERNEE	CS:		Outpt Rec. Rm:	
MC Status:		WS:		PCM:	
Insurance:	No			Tel. PCM:	

CHRONOLOGICAL RECORD OF MEDICAL CARE

STANDARD FORM 600 (REV. 5)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45.505

EXHIBIT 8

0022-08-01789-53207

Patient: CROP, ISN315224
Facility: TF 115th CSH (NORTH) (WBH6A1)

Date: 27 Jun 2008 1007 GST
Clinic: CROPPER HOSPITAL

Appt Type: ROUTN
Provider (b)(6)

AutoCites Refreshed by @ 27 Jun 2008 1742 GST
Problems
visit for administrative purpose
LUNG NEOPLASM MALIGNANT
BRAIN TUMOR MALIGNANT
METASTASIS TO BRAIN
PAPILLEDEMA ASSOCIATED WITH INCREASED INTRACRANIAL PRESSURE
REFRACTIVE ERROR - HYPERMETROPIA
LUNG CANCER

Active Medications
No Active Medications Found.
Allergies
Patient has no known allergies

Screening Written by (b)(6) @ 27 Jun 2008 1007 GST

Appointment Reason For Visit: Unspecified Reason for Visit;

Selected Reason(s) For Visit:
Unspecified Reason For Visit (New) Comments: Question about meds

Vitals Written by (b)(6) @ 27 Jun 2008 1742 AST
BP: 136/82, HR: 101, RR: 18, T: 98.5 °F,

S/O Note Written by (b)(6) @ 27 Jun 2008 1745 GST

History of present illness
The Patient is a 31 year old male.
° Encounter Background Information: Detainee with lung cancer metastatic to the brain; well known to me. Here today to request medication for sleep, states he has been having insomnia. He is on high doses of decadron which may be the cause of this. Also c/o dry, sore throat, would like some treatment for this. Denies f/c/n/v/d or other systemic sxs.
• Otolaryngeal symptoms dry, sore throat.

° No systemic symptoms ° No head symptoms ° No eye symptoms ° No neck symptoms ° No cardiovascular symptoms ° No pulmonary symptoms ° No gastrointestinal symptoms ° No neurological symptoms

Physical findings
Vital signs:
° Normal mild tachycardia
General appearance:
° Normal
Head:
° Normal
Ears, Nose, Throat:
• ENT: o/p clear, no injection or purulent discharge
Neck:
° Normal
Lymph Nodes:
° Normal
Lungs:
° Normal
Cardiovascular system:

Name:CROP, ISN315224

		Sex:	M	Sponsor:	CROP, ISN315224
FMP/SSN:	20/900315224	Tel H:		Rank:	
DOB:	04 Jul 1976	Tel W:		Unit:	
PCat:	K78 FOREIGN NATIONAL-POW/INTERNEE	CS:		Outpt Rec. Rm:	
MC Status:		WS:		PCM:	
Insurance:	No			Tel. PCM:	

° Normal

0022-08-013789-53207

A/P Written by (b)(6) @ 27 Jun 2008 1746 GST
1. insomnia
Comments: - likely steroid induced
- will try elavil 25 mg qhs
2. SORE THROAT
Comments: - no apparent infection
- given cepacol for symptomatic relief

Disposition Written by (b)(6) @ 27 Jun 2008 1747 GST
Released Without Limitations
Follow up: as needed .
Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.
Injury & Illness: Not Work Related; Not Battle Related; Category: All Other, Medical/Surgical Cause: Non-Battle Illness
Appointment Class: Outpatient
E&M Code: 99213 - Estab Outpatient Expanded H&P - Low Complexity Decisions

Signed By (b)(6) @ 27 Jun 2008 1747 GST
(b)(6)
TF 115th CSH (NORTH) (WBH6A1)

Name:CROP, ISN315224

		Sex:	M	Sponsor:	CROP, ISN315224
FMP/SSN:	20/900315224	Tel H:		Rank:	
DOB:	04 Jul 1976	Tel W:		Unit:	
PCat:	K78 FOREIGN NATIONAL-POW/INTERNEE	CS:		Outpt Rec. Rm:	
MC Status:		WS:		PCM:	
Insurance:	No			Tel. PCM:	

CHRONOLOGICAL RECORD OF MEDICAL CARE **STANDARD FORM 600 (REV. 5)**
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45.505

EXHIBIT 9

0022-68-016789-53207

Patient: CROP, ISN315224
Facility: TF 115th CSH (NORTH) (WBH6A1)

Date: 13 Jun 2008 1141 GST
Clinic: CROPPER HOSPITAL

Appt Type: ROUTN
Provider: (b)(6)

AutoCites Refreshed by @ 13 Jun 2008 1700 GST
Problems
visit for: administrative purpose
LUNG NEOPLASM MALIGNANT
BRAIN TUMOR MALIGNANT
METASTASIS TO BRAIN
PAPILLEDEMA ASSOCIATED WITH INCREASED INTRACRANIAL PRESSURE
REFRACTIVE ERROR - HYPERMETROPIA
LUNG CANCER

Active Medications
No Active Medications Found.
Allergies
Patient has no known allergies

Screening Written by (b)(6) @ 13 Jun 2008 1141 GST

Appointment Reason For Visit: LUNG CANCER; BRAIN CANCER;

Selected Reason(s) For Visit:
LUNG CANCER (New) Comments:
BRAIN CANCER (New) Comments:

S/O Note Written by (b)(6) @ 13 Jun 2008 1701 GST

History of present illness
The Patient is a 31 year old male.
° Encounter Background Information: Detainee with lung cancer with metastasis to brain; here today to discuss compassionate release. Release has been granted, but we have had difficulty locating a family member who is willing to take responsibility for the care of this detainee.
Review of systems
Head symptoms: No head symptoms.
Eye symptoms: No eye symptoms.
Cardiovascular symptoms: No cardiovascular symptoms.
Pulmonary symptoms: No pulmonary symptoms.
Gastrointestinal symptoms: No gastrointestinal symptoms.
Genitourinary symptoms: No genitourinary symptoms.
Physical findings
Vital signs:
° Normal.
General appearance:
° Normal.

A/P Written by (b)(6) @ 13 Jun 2008 1704 GST
1. LUNG NEOPLASM MALIGNANT
Comments: - with the assistance of a translator, had an in depth conversation with the detainee about the fact that his compassionate release has been approved, and that we need to locate a family member who is willing to take responsibility for his health care upon his realease. Detainee provided several names and phone numbers, to include his brother and his wife, who he believes will be willing to do this.

Name:CROP, ISN315224

		Sex:	M	Sponsor:	CROP, ISN315224
FMP/SSN:	20/900315224	Tel H:		Rank:	
DOB:	04 Jul 1976	Tel W:		Unit:	
PCat:	K78 FOREIGN NATIONAL-POW/INTERNEE	CS:		Outpt Rec. Rm:	
MC Status:		WS:		PCM:	
Insurance:	No			Tel. PCM:	

0022-08-CID789-53207

- futhermore, detainee states he has visitation coming up on 24 June, at which point his wife and his mother will be coming to visit. Plan is to try to coordinate the release prior to the visitation, or perhaps on the day of the visitation when we can talk with family members in person
- pt is concerned about receiving a copy of his medical record, as well as a supply of medications, upon his release. Reassured him that we would provide a medical record as well as a 2 week supply of meds.

2. METASTASIS TO BRAIN

Comments:

Disposition Written by (b)(6) @ 13 Jun 2008 1704 GST

Released Without Limitations

Follow up: as needed

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.

Injury & Illness: Not Work Related; Not Battle Related; Category: All Other, Medical/Surgical Cause: Non-Battle Illness

Appointment Class: Outpatient

E&M Code: 99213 - Estab Outpatient Expanded H&P - Low Complexity Decisions

Signed By (b)(6) @ 13 Jun 2008 1705 GST

(b)(6)

TF 115th CSH (NORTH) (WBH6A1)

Name:CROP, ISN315224

		Sex:	M	Sponsor:	CROP, ISN315224
FMP/SSN:	20/900315224	Tel H:		Rank:	
DOB:	04 Jul 1976	Tel W:		Unit:	
PCat:	K78 FOREIGN NATIONAL-POW/INTERNEE	CS:		Outpt Rec. Rm:	
MC Status:		WS:		PCM:	
Insurance:	No			Tel. PCM:	

0022-08-610789-53207

Patient: CROP, ISN315224
Facility: TF 115th CSH (NORTH) (WBH6A1)

Date: 02 Jun 2008 1435 GST
Clinic: CROPPER HOSPITAL

Appt Type: ROUTN
Provider: (b)(6)

AutoCites Refreshed by @ 02 Jun 2008 1704 GST
Problems
visit for: administrative purpose
LUNG NEOPLASM MALIGNANT
BRAIN TUMOR MALIGNANT
METASTASIS TO BRAIN
PAPILLEDEMA ASSOCIATED WITH INCREASED INTRACRANIAL PRESSURE
REFRACTIVE ERROR - HYPERMETROPIA

Active Medications
No Active Medications Found
Allergies
Patient has no known allergies

Screening Written by (b)(6) @ 02 Jun 2008 1435 GST

Appointment Reason For Visit: LUNG CANCER;

Selected Reason(s) For Visit:
LUNG CANCER (New) Comments:

S/O Note Written by (b)(6) @ 02 Jun 2008 1707 GST

History of present illness
The Patient is a 31 year old male.
- Head symptoms occasional occipital headache.
- Pulmonary symptoms denies SOB or hemoptysis.

Physical findings
Vital signs:
- Normal.

General appearance:
- Normal.

Lungs:
- Lungs: mild crackles bilat; good air movement.

A/P Written by (b)(6) @ 02 Jun 2008 1707 GST
1. LUNG CANCER
Comments: - reorder decadron at 8 mg bid in an attempt to control pain
- compassionate release paperwork initiated; awaiting outcome
- f/u prn

Disposition Written by (b)(6) @ 02 Jun 2008 1708 GST
Released Without Limitations
Follow up: as needed .
Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.
Injury & Illness: Not Work Related; Not Battle Related; Category: All Other, Medical/Surgical Cause: Non-Battle Illness
Appointment Class: Outpatient
E&M Code: 99212 - Estab Outpatient Focused H&P - Straightforward Decisions

Name:CROP, ISN315224

		Sex:	M	Sponsor:	CROP, ISN315224
FMP/SSN:	20/900315224	Tel H:		Rank:	
DOB:	04 Jul 1976	Tel W:		Unit:	
PCat:	K78 FOREIGN NATIONAL-POW/INTERNEE	CS:		Outpt Rec. Rm:	
MC Status:		WS:		PCM:	
Insurance:	No			Tel. PCM:	

10 minutes face-to-face/floor time.

0022-[illegible]-39-53207

Signed By (b)(6) @ 02 Jun 2008 1709 GST
(b)(6)
TF 31 CSH (NORTH) (WBKXA1)

Name:CROP, ISN315224

		Sex:	M	Sponsor:	CROP, ISN315224
FMP/SSN:	20/900315224	Tel H:		Rank:	
DOB:	04 Jul 1976	Tel W:		Unit:	
PCat:	K78 FOREIGN NATIONAL-POW/INTERNEE	CS:		Outpt Rec. Rm:	
MC Status:		WS:		PCM:	
Insurance:	No			Tel. PCM:	

0022-08-010789-53207

Patient: CROP, C600315224
Facility: TF 31 CSH (NORTH) (WBKXA1)

Date: 31 May 2008 1126 AST
Clinic: OPTOMETRY

Appt Type: ROUTN
Provider: (b)(6)

Appointment Cancelled by Facility

Encounter Cancelled by (b)(6) @ 31 May 2008 1126 AST

Name:CROP, ISN315224

		Sex:	M	Sponsor:	CROP, ISN315224
FMP/SSN:	20/900315224	Tel H:		Rank:	
DOB:	04 Jul 1976	Tel W:		Unit:	
PCat:	K78 FOREIGN NATIONAL-POW/INTERNEE	CS:		Outpt Rec. Rm:	
MC Status:		WS:		PCM:	
Insurance:	No			Tel. PCM:	

CHRONOLOGICAL RECORD OF MEDICAL CARE

STANDARD FORM 600 (REV. 5)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45.505

EXHIBIT 4

0022-08-0107 89-53207

Patient: CROP, ISN315224
Facility: TF 115th CSH (NORTH) (WBH6A1)

Date: 29 May 2008 1414 GST
Clinic: CROPPER HOSPITAL

Appt Type: ROUTN
Provider: (b)(6)

AutoCites Refreshed by @ 29 May 2008 1740 GST
Problems
visit for: administrative purpose
LUNG NEOPLASM MALIGNANT
BRAIN TUMOR MALIGNANT
METASTASIS TO BRAIN
PAPILLEDEMA ASSOCIATED WITH INCREASED INTRACRANIAL PRESSURE
REFRACTIVE ERROR - HYPERMETROPIA

Active Medications
No Active Medications Found.
Allergies
Patient has no known allergies

Screening Written by (b)(6) @ 29 May 2008 1414 GST

Appointment Reason For Visit: BRAIN TUMOR MALIGNANT:

Selected Reason(s) For Visit:
BRAIN TUMOR MALIGNANT (Follow-Up) Comments:

S/O Note Written by (b)(6) @ 29 May 2008 1433 GST

History of present illness
The Patient is a 31 year old male.
° Encounter Background Information: PATIENT NOT HERE FOR - ENCOUNTER IS FOR INFORMATION PURPOSES ONLY. THIS DETAINEE'S COMPASSIONATE RELEASE WAS DECLINED TWICE, MOST RECENTLY 31 MAR 08. HE IS TO CONTINUE THE DECADRON 4 MG QID WITH TITRATION DOWN TO BID IS THERE ARE NO NEURO SYMPTOMS. SPOKE WITH (b)(6) TODAY WHO PREFERS THAT THIS PATIENT STAY ON DECADRON, NOT SWITCHED TO PREDNISONE.

A/P Written by (b)(6) @ 29 May 2008 1749 GST
1. METASTASIS TO BRAIN
Comments:

Disposition Written by (b)(6) @ 29 May 2008 1749 GST
Released Without Limitations
Injury & Illness: Not Work Related; Not Battle Related; Category: Misc/Administration/Follow-Up Cause: Non-Battle Illness
Appointment Class: Outpatient
E&M Code: 99212 - Estab Outpatient Focused H&P - Straightforward Decisions

Signed By (b)(6) @ 29 May 2008 1749 GST
(b)(6)
TF 31 CSH (NORTH) (WBKXA1)

Name:CROP, ISN315224

		Sex:	M	Sponsor:	CROP, ISN315224
FMP/SSN:	20/900315224	Tel H:		Rank:	
DOB:	04 Jul 1976	Tel W:		Unit:	
PCat:	K78 FOREIGN NATIONAL-POW/INTERNEE	CS:		Outpt Rec. Rm:	
MC Status:		WS:		PCM:	
Insurance:	No			Tel. PCM:	

0022-08-CID789-53207

Patient: CROP, C600315224
Facility: TF 31 CSH (NORTH) (WBKXA1)
Date: 27 May 2008 1211 AST
Clinic: CROPPER HOSPITAL
Appt Type: SCALL
Provider: (b)(6)

AutoCites Refreshed by @ 28 May 2008 1854 AST

Problems

visit for: administrative purpose
LUNG NEOPLASM MALIGNANT
BRAIN TUMOR MALIGNANT
METASTASIS TO BRAIN
PAPILLEDEMA ASSOCIATED WITH INCREASED INTRACRANIAL PRESSURE
REFRACTIVE ERROR - HYPERMETROPIA

Active Medications

No Active Medications Found.

Allergies

Patient has no known allergies

Vitals Written by (b)(6) @ 28 May 2008 1854 AST

Comments: Not in compound.

Appointment Cancelled by Facility

Encounter Cancelled by (b)(6) @ 28 May 2008 1854 AST

Name:CROP, ISN315224

		Sex:	M	Sponsor:	CROP, ISN315224
FMP/SSN:	20/900315224	Tel H:		Rank:	
DOB:	04 Jul 1976	Tel W:		Unit:	
PCat:	K78 FOREIGN NATIONAL-POW/INTERNEE	CS:		Outpt Rec. Rm:	
MC Status:		WS:		PCM:	
Insurance:	No			Tel. PCM:	

0022-08-CID-89-53207

Patient: CROP, ISN315224
Facility: TF 115th CSH (NORTH) (WBH6A1)

Date: 16 May 2008 1406 GST
Clinic: CROPPER HOSPITAL

Appt Type: ROUTN
Provider: (b)(6)

AutoCites Refreshed by @ 16 May 2008 1725 GST
Problems
visit for: administrative purpose
LUNG NEOPLASM MALIGNANT
BRAIN TUMOR MALIGNANT
METASTASIS TO BRAIN

Active Medications
No Active Medications Found.
Allergies
Patient has no known allergies

Screening Written by (b)(6) @ 16 May 2008 1406 GST

Appointment Reason For Visit: BRAIN CANCER;

Selected Reason(s) For Visit:
BRAIN CANCER (New) Comments:

Vitals Written by (b)(6) @ 16 May 2008 1725 AST
BP: 136/85, HR: 93, RR: 16, T: 99.1 °F,

S/O Note Written by (b)(6) @ 16 May 2008 1735 GST

Chief complaint
The Chief Complaint is: F/U lung CA with brain mets.
History of present illness
The Patient is a 31 year old male.
° Encounter Background Information: 43 YO with H/O lung CA diagnosed Jun07; later diagnosed with metastases to brain. No sz, but C/O H/A and "dizziness". Decadron sometimes causes upset stomach - was better with Zantac, but this med was recently D/C'ed. L face feels mildly weak/numb. No other C/O.
- Head symptoms C/O H/A.
Past medical/surgical history
Reported History:
Past medical history lung CA with brain mets, as above.
Personal history
Behavioral history: Tobacco use.
Review of systems
Systemic symptoms: No systemic symptoms.
Eye symptoms: No eye symptoms.
Otolaryngeal symptoms: No otolaryngeal symptoms.
Cardiovascular symptoms: No cardiovascular symptoms.
Pulmonary symptoms: Pulmonary symptoms mild, intermittent SOB.
Gastrointestinal symptoms: Gastrointestinal symptoms stomach upset with Decadron.
Genitourinary symptoms: No genitourinary symptoms.
Neurological symptoms: Neurological symptoms H/A, mild L face weakness/numbness.
Physical findings
General appearance:
° Awake. ° Alert. ° In no acute distress.
Lungs:
° Clear to auscultation. ° No wheezing was heard. ° No rhonchi were heard.
Cardiovascular system:

Name:CROP, ISN315224

		Sex:	M	Sponsor:	CROP, ISN315224
FMP/SSN:	20/900315224	Tel H:		Rank:	
DOB:	04 Jul 1976	Tel W:		Unit:	
PCat:	K78 FOREIGN NATIONAL-POW/INTERNEE	CS:		Outpt Rec. Rm:	
MC Status:		WS:		PCM:	
Insurance:	No			Tel. PCM:	

Heart Rate And Rhythm: ° Normal.
Heart Sounds: ° Normal.
Murmurs: ° No murmurs were heard.

Neurological:

- System: mild central-pattern L facial weakness. Otherwise, CN intact. Motor 5/5. Gait normal.

A/P Written by (b)(6) @ 16 May 2008 1738 GST

1. LUNG NEOPLASM MALIGNANT

Comments:

2. BRAIN TUMOR MALIGNANT

Comments: Lung CA with mets to brain. Continue Decadron 4mg Q6 hours. Restart Zantac 150mg BID.

Tylenol 325mg TID for chronic H/A.

Check on status of Compassionate Release paperwork.

RTC 1 month.

Disposition Written by (b)(6) @ 16 May 2008 1738 GST

Released Without Limitations

Follow up: 1 month(s) in the DMC clinic or sooner if there are problems.

Discussed: Diagnosis, Medication(s)/Treatment(s) with Patient who indicated understanding.

Injury & Illness: Not Work Related; Not Battle Related; Category: All Other, Medical/Surgical Cause: Non-Battle Illness

Appointment Class: Outpatient

E&M Code: 99213 - Estab Outpatient Expanded H&P - Low Complexity Decisions

Signed By (b)(6) @ 16 May 2008 1738 GST
(b)(6)
TF 31 CSH (NORTH) (WBKXA1)

Name:CROP, ISN315224

		Sex:	M	Sponsor:	CROP, ISN315224
FMP/SSN:	20/900315224	Tel H:		Rank:	
DOB:	04 Jul 1976	Tel W:		Unit:	
PCat:	K78 FOREIGN NATIONAL-POW/INTERNEE	CS:		Outpt Rec. Rm:	
MC Status:		WS:		PCM:	
Insurance:	No			Tel. PCM:	

0022-08-CID789-53207

Patient: CROP, ISN315224
Facility: TF 115th CSH (NORTH) (WBH6A1)

Date: 14 May 2008 1150 GST
Clinic: OPTOMETRY

Appt Type: ROUTN
Provider: (b)(6)

AutoCites Refreshed by @ 18 May 2008 1716 GST

Problems
visit for: administrative purpose
LUNG NEOPLASM MALIGNANT
BRAIN TUMOR MALIGNANT
METASTASIS TO BRAIN

Active Medications
No Active Medications Found.
Allergies
Patient has no known allergies

A/P Written by (b)(6) @ 18 May 2008 1720 GST

1. PAPILLEDEMA ASSOCIATED WITH INCREASED INTRACRANIAL PRESSURE
Comments:
Procedure(s): -Ophthalmological New Patient Start Comprehensive Care

2. REFRACTIVE ERROR - HYPERMETROPIA
Comments:
Procedure(s): -Spectacles Services Fitting Monofocals (Not For Aphakia)
-Determination Of Refractive State

Disposition Written by (b)(6) @ 18 May 2008 1720 GST

Released Without Limitations
Injury & Illness: Not Work Related; Not Battle Related; Category: Ophthalmologic Cause: Non-Battle Illness
Appointment Class: Outpatient
E&M Code: 99211 - Established Outpatient Minimal Service

Signed By (b)(6) @ 18 May 2008 1721 GST
(b)(6)

Name:CROP, ISN315224

		Sex:	M	Sponsor:	CROP, ISN315224
FMP/SSN:	20/900315224	Tel H:		Rank:	
DOB:	04 Jul 1976	Tel W:		Unit:	
PCat:	K78 FOREIGN NATIONAL-POW/INTERNEE	CS:		Outpt Rec. Rm:	
MC Status:		WS:		PCM:	
Insurance:	No			Tel. PCM:	

CHRONOLOGICAL RECORD OF MEDICAL CARE

STANDARD FORM 600 (REV. 5)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45.505

0022-08-00789-53207

Patient: CROP, ISN315224
Facility: TF 115th CSH (NORTH) (WBH6A1)

Date: 25 Apr 2008 1057 GST
Clinic: CROPPER HOSPITAL

Appt Type: ROUTN
Provider: (b)(6)

AutoCites Refreshed by @ 25 Apr 2008 1505 GST
Problems
visit for: administrative purpose
LUNG NEOPLASM MALIGNANT
BRAIN TUMOR MALIGNANT
METASTASIS TO BRAIN

Active Medications
No Active Medications Found.
Allergies
Patient has no known allergies

Screening Written by (b)(6) @ 25 Apr 2008 1057 GST

Appointment Reason For Visit: BRAIN TUMOR MALIGNANT:

Selected Reason(s) For Visit:
BRAIN TUMOR MALIGNANT (Follow-Up) Comments:

Vitals Written by (b)(6) @ 25 Apr 2008 1410 AST
BP: 126/85, HR: 101, RR: 18, T: 101 °F,

S/O Note Written by (b)(6) @ 25 Apr 2008 1426 GST
Chief complaint
The Chief Complaint is: F/ubrain mets

Reason for Visit
Visit for: f/u of brain mets. Pt. is currently without sxs while on dexamethasone 4mg qid.

History of present illness
The Patient is a 31 year old male.
" Encounter Background Information: seen in dmc every five days

Past medical/surgical history
Reported History:
Past medical history Pt. was dx with lung CA, now has mets to brain.

Review of systems
Systemic symptoms: No systemic symptoms.
Eye symptoms: No eye symptoms.
Otolaryngeal symptoms: No otolaryngeal symptoms.
Neck symptoms: No neck symptoms.
Cardiovascular symptoms: No cardiovascular symptoms.
Pulmonary symptoms: No pulmonary symptoms.
Gastrointestinal symptoms: No gastrointestinal symptoms.
Genitourinary symptoms: No genitourinary symptoms.
Skin symptoms: No skin symptoms.
Musculoskeletal symptoms: No musculoskeletal symptoms.
Neurological symptoms: No neurological symptoms He denies speech, visual, hearing and motor deficits.

Physical findings
Vital signs:

Name:CROP, ISN315224

		Sex:	M	Sponsor:	CROP, ISN315224
FMP/SSN:	20/900315224	Tel H:		Rank:	
DOB:	04 Jul 1976	Tel W:		Unit:	
PCat:	K78 FOREIGN NATIONAL-POW/INTERNEE	CS:		Outpt Rec. Rm:	
MC Status:		WS:		PCM:	
Insurance:	No			Tel. PCM:	

0022-08-CID789-53207

° Normal.

General appearance:

• Patient was not awake. • Patient was not alert. • Patient appeared to be in acute distress. ° Body odor was normal.

Lungs:

° Clear to auscultation. ° No wheezing was heard. ° No rhonchi were heard.

Cardiovascular system:

Heart Rate And Rhythm: ° Normal.
Heart Sounds: ° Normal.
Murmurs: ° No murmurs were heard.

Neurological:

Gait And Stance: ° Normal.

A/P Written by (b)(6) @ 25 Apr 2008 1421 GST

1. METASTASIS TO BRAIN

Comments: Reduced Dexamethasone dose from qid to tid.
Will reduce dose to bid in two weeks if continues to do well.

Disposition Last updated by (b)(6) @ 25 Apr 2008 1506 GST

Released Without Limitations
Follow up: 5 day(s) with PCM or sooner if there are problems.
Discussed: Diagnosis, Medication(s)/Treatment(s) with Patient who indicated understanding.
Injury & Illness: Not Work Related; Not Battle Related; Category: All Other, Medical/Surgical Cause: Non-Battle Illness
Appointment Class: Outpatient
E&M Code: 99213 - Estab Outpatient Expanded H&P - Low Complexity Decisions

Signed By (b)(6) @ 25 Apr 2008 1506 GST
(b)(6)
TF 31 CSH (NORTH) (WBKXA1)

CHANGE HISTORY

The following Disposition Note Was Overwritten by (b)(6) @ 25 Apr 2008 1506 GST:
Disposition section was last updated by (b)(6) @ 25 Apr 2008 1506 AST - see above.Previous Version of Disposition section was entered/updated by (b)(6) @ 25 Apr 2008 1427 AST.
Released Without Limitations
Follow up: as needed with PCM.
Discussed: Diagnosis, Medication(s)/Treatment(s) with Patient who indicated understanding.
Injury & Illness: Not Work Related; Not Battle Related; Category: All Other, Medical/Surgical Cause: Non-Battle Illness
Appointment Class: Outpatient
E&M Code: 99213 - Estab Outpatient Expanded H&P - Low Complexity Decisions

The following AutoCites Were Overwritten by (b)(6) @ 25 Apr 2008 1505 GST:
AutoCites Refreshed by (b)(6) @ 25 Apr 2008 1409 AST

Problems
visit for: administrative purpose
LUNG NEOPLASM MALIGNANT
BRAIN TUMOR MALIGNANT

Active Medications
No Active Medications Found.

Allergies
Patient has no known allergies

Name:CROP, ISN315224

		Sex:	M	Sponsor:	CROP, ISN315224
FMP/SSN:	20/900315224	Tel H:		Rank:	
DOB:	04 Jul 1976	Tel W:		Unit:	
PCat:	K78 FOREIGN NATIONAL-POW/INTERNEE	CS:		Outpt Rec. Rm:	
MC Status:		WS:		PCM:	
Insurance:	No			Tel. PCM:	

0022-08-010-00-57207

The following Signature(s) No Longer Applies because this Encounter Was Opened for Amendment by (b)(6) @ *25 Apr 2008 1505 GST:*

Signed (b)(6) (TF 31 CSH (NORTH) (WBKXA1)) @ 25 Apr 2008 1427

Name:CROP, ISN315224

		Sex:	M	Sponsor:	CROP, ISN315224
FMP/SSN:	20/900315224	Tel H:		Rank:	
DOB:	04 Jul 1976	Tel W:		Unit:	
PCat:	K78 FOREIGN NATIONAL-POW/INTERNEE	CS:		Outpt Rec. Rm:	
MC Status:		WS:		PCM:	
Insurance:	No			Tel. PCM:	

EXHIBIT 8

0022-20-CID-00-53207

Patient: CROP, ISN315224
Facility: TF 115th CSH (NORTH) (WBH6A1)

Date: 20 Apr 2008 0844 GST
Clinic: CROPPER HOSPITAL

Appt Type: ROUTN
Provider: (b)(6)

AutoCites Refreshed by @ 20 Apr 2008 1258 GST
Problems
visit for: administrative purpose
LUNG NEOPLASM MALIGNANT
BRAIN TUMOR MALIGNANT

Active Medications
No Active Medications Found.
Allergies
Patient has no known allergies

Screening Written by (b)(6) @ 20 Apr 2008 0844 GST

Appointment Reason For Visit: BRAIN TUMOR MALIGNANT;

Selected Reason(s) For Visit:
BRAIN TUMOR MALIGNANT (Follow-Up) Comments:

Vitals Written by (b)(6) @ 20 Apr 2008 1258 AST
BP: 130/80, HR: 122, RR: 16, T: 98.4 °F,

S/O Note Written by (b)(6) @ 20 Apr 2008 1300 GST
Chief complaint
The Chief Complaint is: BRAIN METASTATIS

History of present illness
The Patient is a 31 year old male.
° Encounter Background Information: PRESENTLY ON DECADRON 4MG QID

Past medical/surgical history
Reported History:
Past medical history LUNG CA WITH BRAIN METS

Review of systems
Systemic symptoms: No systemic symptoms.
Eye symptoms: No eye symptoms.
Otolaryngeal symptoms: No otolaryngeal symptoms.
Neck symptoms: No neck symptoms.
Cardiovascular symptoms: No cardiovascular symptoms.
Pulmonary symptoms: No pulmonary symptoms.
Gastrointestinal symptoms: No gastrointestinal symptoms.
Genitourinary symptoms: No genitourinary symptoms.
Skin symptoms: No skin symptoms.
Musculoskeletal symptoms: Musculoskeletal symptoms.
Neurological symptoms: Neurological symptoms.
Physical findings
Vital signs:
° Normal.
General appearance:
° Patient was awake. ° Patient was alert. ° Patient appeared to be in no acute distress.
Lungs:
• Pulmonary auscultation revealed abnormalities MARKEDLY DEMINISHED EXPIRATORY SOUNDS

Name:CROP, ISN315224

		Sex:	M	Sponsor:	CROP, ISN315224
FMP/SSN:	20/900315224	Tel H:		Rank:	
DOB:	04 Jul 1976	Tel W:		Unit:	
PCat:	K78 FOREIGN NATIONAL-POW/INTERNEE	CS:		Outpt Rec. Rm:	
MC Status:		WS:		PCM:	
Insurance:	No			Tel. PCM:	

EXHIBIT 8

0022-08-010789-53207

° No wheezing was heard. ° No rhonchi were heard.

Cardiovascular system:

Heart Rate And Rhythm: ° Normal.
Heart Sounds: ° Normal.
Murmurs: ° No murmurs were heard.

Neurological:

• System: RLE WEAKNESS

A/P Written by (b)(6) @ 20 Apr 2008 1301 GST

1. BRAIN TUMOR MALIGNANT

Comments: WILL NOT DECREASE DECADRON TO TID AS PLANNED BECAUSE OF NEURO SYMPTOMS OF RLE WEAKNESS.

Disposition Written by (b)(6) @ 20 Apr 2008 1301 GST

Released Without Limitations

Follow up: as needed in 5 day(s) with PCM and/or in the DMC clinic or sooner if there are problems.
Discussed: Diagnosis, Medication(s)/Treatment(s) with Patient who indicated understanding.
Injury & Illness: Not Work Related; Not Battle Related; Category: All Other, Medical/Surgical Cause: Non-Battle Illness
Appointment Class: Outpatient
E&M Code: 99213 - Estab Outpatient Expanded H&P - Low Complexity Decisions

Signed By (b)(6) @ 20 Apr 2008 1301 GST
(b)(6)
TF 31 CSH (NORTH) (WBKXA1)

Name:CROP, ISN315224

		Sex:	M	Sponsor:	CROP, ISN315224
FMP/SSN:	20/900315224	Tel H:		Rank:	
DOB:	04 Jul 1976	Tel W:		Unit:	
PCat:	K78 FOREIGN NATIONAL-POW/INTERNEE	CS:		Outpt Rec. Rm:	
MC Status:		WS:		PCM:	
Insurance:	No			Tel. PCM:	

0022-08-10789-53207

Patient: CROP, ISN315224
Facility: TF 115th CSH (NORTH) (WBH6A1)

Date: 15 Apr 2008 1119 GST
Clinic: CROPPER HOSPITAL

Appt Type: ROUTN
Provider: (b)(6)

AutoCites Refreshed by @ 15 Apr 2008 1345 GST
Problems
visit for: administrative purpose
LUNG NEOPLASM MALIGNANT

Active Medications
No Active Medications Found.
Allergies
No Allergies Found.

Screening Written by (b)(6) @ 15 Apr 2008 1345 GST

Appointment Reason For Visit: **BRAIN TUMOR MALIGNANT**

Selected Reason(s) For Visit:
BRAIN TUMOR MALIGNANT (New) Comments:

Vitals Written by (b)(6) @ 15 Apr 2008 1345 AST
BP: 128/77, HR: 103, RR: 16, T: 98.5 °F,

S/O Note Written by (b)(6) @ 15 Apr 2008 1353 GST
Chief complaint
The Chief Complaint is: BRAIN METS

History of present illness
The Patient is a 31 year old male.
° Encounter Background Information: ORIGINALLY DXED WITH LUNG CANCER WHEN SCREENING CXR WAS DONE AFTER CAPTURE JUNE 2007. APX. 1 MONTH AGO, AT BUCCA, HE WAS DXED WITH METS TO THE BRAIN

• Head symptoms NUMBNESS - RIGHT SIDE OF HEAD

Past medical/surgical history
Reported History:
Past medical history CANCER

Review of systems
Systemic symptoms: Systemic symptoms.
Eye symptoms: No eye symptoms.
Otolaryngeal symptoms: No otolaryngeal symptoms.
Neck symptoms: No neck symptoms.
Cardiovascular symptoms: No cardiovascular symptoms.
Pulmonary symptoms: No pulmonary symptoms.
Gastrointestinal symptoms: No gastrointestinal symptoms.
Genitourinary symptoms: No genitourinary symptoms.
Skin symptoms: No skin symptoms.
Musculoskeletal symptoms: No musculoskeletal symptoms.
Neurological symptoms: No neurological symptoms.
Physical findings
Vital signs:
° Normal.
Standard Measurements:
• Weight VERY THIN

Name:CROP, ISN315224

		Sex:	M	Sponsor:	CROP, ISN315224
FMP/SSN:	20/900315224	Tel H:		Rank:	
DOB:	04 Jul 1976	Tel W:		Unit:	
PCat:	K78 FOREIGN NATIONAL-POW/INTERNEE	CS:		Outpt Rec. Rm:	
MC Status		WS:		PCM:	
Insurance:	No			Tel. PCM:	

0022-08-8189-53207

General appearance:
° Patient was awake. ° Patient was alert. ° Patient appeared to be in no acute distress.
Lungs:
• Pulmonary auscultation revealed abnormalities NO SOUNDS WITH EXPIRATION
° No wheezing was heard. ° No rhonchi were heard.
Cardiovascular system:
Heart Rate And Rhythm: ° Normal.
Heart Sounds: ° Normal.
Murmurs: ° No murmurs were heard.
Neurological:
Motor: ° A motor exam demonstrated no dysfunction.
Gait And Stance: ° Normal.

A/P Written by (b)(6) @ 15 Apr 2008 1412 GST
1. LUNG NEOPLASM MALIGNANT
Comments:
2. BRAIN TUMOR MALIGNANT
Comments: CROP,C600224 Age:43 20/600-31-5224 OUTPAT POL
1 RX DEXAMETHASONE--PO 4MG TAB~TAKE 1 TAB PO QID RF2 #120 DS30 on 15 Apr 2008@1303 (m
-1) (Not Dispensed) . . . . . WILLIC 15APR@1303

Disposition Written by (b)(6) @ 15 Apr 2008 1412 GST
Released Without Limitations
Follow up: with PCM and/or in the DMC clinic. - Comments: ON 20 APRIL 08
Discussed: Diagnosis, Medication(s)/Treatment(s) with Patient who indicated understanding.
Injury & Illness: Not Work Related; Not Battle Related; Category: All Other, Medical/Surgical Cause: Non-Battle Illness
Appointment Class: Outpatient
E&M Code: 99213 - Estab Outpatient Expanded H&P - Low Complexity Decisions

Note Written by (b)(6) @ 15 Apr 2008 1412 GST
DISCUSSED CASE WITH (b)(6) ONCOLOGIST) WHO GAVE THE FOLLOWING GUIDANCE: PATIENT SHOULD BE ON DECADRON 4 MG QID, DECREASE TO 4 MG TID IN 4-5 DAYS AND DECREASE TO 4 MG BID 4-5 DAYS AFTER THAT. MAINTENANCE DOSE IS 4 MG BID AS LONG AS PATIENT DOES NOT HAVE SYMPTOMS OF HA, WEAKNESS, SPEECH PROBLEMS, SWALLOWING, OR ANY OTHER NEURO SYMPTOMS. IF SYMPTOMS OCCUR INCREASE DECADRON BACK TO QID.

Signed By (b)(6) @ 15 Apr 2008 1415 GST
(b)(6)
TF 31 CSH (NORTH) (WBKXA1)

CHANGE HISTORY

The following Screening Note Was Overwritten by (b)(6) @ 15 Apr 2008 1345 GST:
Screening Written by (b)(6) @ 15 Apr 2008 1119 AST

Appointment Reason For Visit: CT Scan;

Selected Reason(s) For Visit:
CT Scan (New) Comments:

Name:CROP, ISN315224

		Sex:	M	Sponsor:	CROP, ISN315224
FMP/SSN:	20/900315224	Tel H:		Rank:	
DOB:	04 Jul 1976	Tel W:		Unit:	
PCat:	K78 FOREIGN NATIONAL-POW/INTERNEE	CS:		Outpt Rec. Rm:	
MC Status:		WS:		PCM:	
Insurance:	No			Tel. PCM:	

0022-SP-010-09-E3207

Patient: CROP, ISN315224
Facility: TF 115th CSH (NORTH) (WBH6A1)

Date: 13 Jun 2007 1005 GST
Clinic: CROPPER HOSPITAL

Appt Type: ROUTN
Provider: (b)(6)

AutoCites Refreshed by @ 14 Jun 2007 0720 GST
Problems
visit for: administrative purpose

Active Medications
No Active Medications Found.
Allergies
No Allergies Found.

Screening Written by (b)(6) @ 13 Jun 2007 1005 GST

Appointment Reason For Visit: Ulcer (cm);

Selected Reason(s) For Visit:
Ulcer (___cm) (New) Comments:

Vitals Written by (b)(6) @ 14 Jun 2007 0720 AST
BP: 109/87, HR: 86, RR: 14, T: 99 °F,

S/O Note Written by (b)(6) @ 14 Jun 2007 0729 GST
Chief complaint
The Chief Complaint is: Here for results of CT

History of present illness
The Patient is a 30 year old male.
Pt states he is 42 years old who requests results of CT. he had a CXR that showed a mass. CT showed a spiculated mass that was consistent with a cancer. Per general surgery, it was recommended that pt have a CR b/c of the lack of services here at our CSH. Pt has a 4PPD x 30 yrs smoking history.

Physical findings
Vital signs:
° Current vital signs reviewed.
General appearance:
° Patient appeared to be in no acute distress.
Lungs:
° Clear to auscultation.
Cardiovascular system:
Heart Rate And Rhythm: ° Normal.
Heart Sounds: ° Normal.
Abdomen:
Visual Inspection: ° Abdomen was normal on visual inspection.
Auscultation: ° Abdominal auscultation revealed no abnormalities.
Palpation: ° Abdominal palpation revealed no abnormalities.

A/P Written by (b)(6) @ 14 Jun 2007 0731 GST
1. LUNG NEOPLASM MALIGNANT
Comments: Per (b)(6) a CR was submitted. Will wait for response. Pt was told about his cancer. Told patient that we will bring him back when we have the definitive answer for his release vs treatment options.

Disposition Written by (b)(6) @ 14 Jun 2007 0731 GST
Released Without Limitations

Name:CROP, ISN315224

		Sex:	M	Sponsor:	CROP, ISN315224
FMP/SSN:	20/900315224	Tel H:		Rank:	
DOB:	04 Jul 1976	Tel W:		Unit:	
PCat:	K78 FOREIGN NATIONAL-POW/INTERNEE	CS:		Outpt Rec. Rm:	
MC Status:		WS:		PCM:	
Insurance:	No			Tel. PCM:	

0022-08-010789-53207

Follow up: as needed
Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.
Injury & Illness: Not Work Related; Not Battle Related; Category: All Other, Medical/Surgical Cause: Non-Battle Illness
Appointment Class: Outpatient
E&M Code: 99212 - Estab Outpatient Focused H&P - Straightforward Decisions

Signed By (b)(6) @ 14 Jun 2007 0731 GST
(b)(6)
TF 31 CSH (NORTH) (WBKXA1)

Name:CROP, ISN315224

		Sex:	M	Sponsor:	CROP, ISN315224
FMP/SSN:	20/900315224	Tel H:		Rank:	
DOB:	04 Jul 1976	Tel W:		Unit:	
PCat:	K78 FOREIGN NATIONAL-POW/INTERNEE	CS:		Outpt Rec. Rm:	
MC Status:		WS:		PCM:	
Insurance:	No			Tel. PCM:	

0022-08-010-89-53207

Patient: CROP,C600315224, DEXTOR
Facility: TF 31 CSH (NORTH) (WBKXA1)
Date: 04 Jun 2007 0950 AST
Clinic: CROPPER HOSPITAL
Appt Type: ROUTN
Provider: (b)(6)

AutoCites Refreshed by (b)(6) @ 04 Jun 2007 0951 AST
Problems
No Problems Found.
Active Medications
No Active Medications Found.
Allergies
No Allergies Found.

Screening Written by (b)(6) @ 04 Jun 2007 0950 AST

Appointment Reason For Visit: Test Results (Use For Free Text):

Selected Reason(s) For Visit:
Test Results (Use For Free Text) (New) Comments:

SO Note Written by (b)(6) @ 04 Jun 2007 0952 AST
History of present illness
The Patient is a 30 year old male.
* Encounter Background Information: SEE BELOW (ADD NOTE) FOR READING OF CXR AND FOLLOW-UP CT

A/P Written by (b)(6) @ 04 Jun 2007 0952 AST
1. visit for: administrative purpose
Comments:

Disposition Written by (b)(6) @ 04 Jun 2007 0956 AST
Released Without Limitations
Follow up: with PCM. - Comments: CONSULT WRITTEN FOR GENERAL SURGICAL EVALUATION
Injury & Illness: Not Work Related; Not Battle Related; Category: Misc/Administration/Follow-Up Cause: Non-Battle Illness
Appointment Class: Outpatient
E&M Code: 99211 - Established Outpatient Minimal Service

Note Written by (b)(6) @ 04 Jun 2007 0952 AST

(b)(6)

IMAGE

RADIOLOGY REPORT

PATIENT NAME 315224
DATE OF BIRTH 11111111
PATIENT NUMBER 315224
REFERRING PHYSICIAN ^
MODALITY TYPE CR
INSTITUTION NAME US ARMY
EXAM DATE 20070601
EXAM TYPE

STUDY COMMENTS

HISTORY

COMPARISON EXAMINATIONS

None.

FINDINGS AND IMPRESSION

40 x 26 mm spiculated mass in RUL overlying 1st anterior rib w/ associated pleural thickening and retraction. This could reflect a malignancy. Rec: CT.

(b)(6)

Name:CROP, ISN315224

		Sex:	M	Sponsor:	CROP, ISN315224
FMP/SSN:	20/900315224	Tel H:		Rank:	
DOB:	04 Jul 1976	Tel W:		Unit:	
PCat:	K78 FOREIGN NATIONAL-POW/INTERNEE	CS:		Outpt Rec. Rm:	
MC Status:		WS:		PCM:	
Insurance:	No			Tel. PCM:	

CHRONOLOGICAL RECORD OF MEDICAL CARE

STANDARD FORM 600 (REV. 5)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45.505

RADIOLOGY REPORT

PATIENT NAME 315224
DATE OF BIRTH
PATIENT NUMBER 315224
REFERRING PHYSICIAN (b)(6)
MODALITY TYPE CT
INSTITUTION NAME TF 21 Med
EXAM DATE 20070602
EXAM TYPE 2 JUN 07

STUDY COMMENTS

HISTORY

FINDINGS AND IMPRESSION

Exam limited by detector artifact due ot overheating. Emphysematous changes present at both apices and medial lungs bilaterally. 32 x 28 mm spiculated mass in posterior segment of right upper lobe with mild peribronchial thickening proximal to mass and strands of soft tissue extending toward pleural margin; difficult to distinguish between infiltration to pleora and passive atelectasis related to bullous changes. No evident regional hilar or mediastinal adenopathy. Overall most compatible with primary lung carcinoma radiographic staging T2N0Mx.

If patient is a candidate for therapy then consider repeat CT to establish adequate imaging baseline and surgical consultation.

(b)(6)

DIGITAL SIGNATURE

file:///C:/Documents and Settings (b)(6) Local Settings\Temporary Internet File... 6/2/2007

Signed By @ 04 Jun 2007 0957
(b)(6)
TF 31 CSH (NORTH) (WBKXA1)

Note Written by (b)(6) @ 09 Jun 2007 0903 AST
(Added after encounter was signed.)
GENERAL SURGERY RESPONSE:
(b)(6) WILL OBTAIN ANOTHER CHEST CT (NEW MACHINE) TO BETTER DELINEATE ANATOMY. HOWEVER, GIVEN HIS APPARENT STATE OF HEALTH, FORMER 4 PACK A DAY SMOKING HISTORY AND 24 LB WEIGHT LOSS OVER 3 MONTHS A CR IS RECOMMENDED. PURSUING SURGICAL THERAPY WITHOUT A FULL WORKUP (CARDIAC,

Name:CROP, ISN315224

		Sex:	M	Sponsor:	CROP, ISN315224
FMP/SSN:	20/900315224	Tel H:		Rank:	
DOB:	04 Jul 1976	Tel W:		Unit:	
PCat:	K78 FOREIGN NATIONAL-POW/INTERNEE	CS:		Outpt Rec. Rm:	
MC Status:		WS:		PCM:	
Insurance:	No			Tel. PCM:	

0022-08-0109-83207

PULMONARY, ETC) IS BEYOND THE PRESENT CSH MEDICAL CAPABILITIES.

Name:CROP, ISN315224

		Sex:	M	Sponsor:	CROP, ISN315224
FMP/SSN:	20/900315224	Tel H:		Rank:	
DOB:	04 Jul 1976	Tel W:		Unit:	
PCat:	K78 FOREIGN NATIONAL-POW/INTERNEE	CS:		Outpt Rec. Rm:	
MC Status:		WS:		PCM:	
Insurance:	No			Tel. PCM:	

CHRONOLOGICAL RECORD OF MEDICAL CARE

STANDARD FORM 600 (REV. 5)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45.505

0022-08-CID789-53207

DEPARTMENT OF THE ARMY
TF 115TH MEDICAL
CAMP CROPPER
APO AE 09342

REPLY TO
ATTENTION OF

FICI-MB-CHA-DCCS

31 July 2008

MEMORANDUM FOR RECORD

SUBJECT: Ethics Consultation, ISN 315224

1. Purpose: Opinion of the MTF Ethics Committee, convened 31 July 2008 T 0930, at TF 115th MED (Cropper), Iraq.

2. Patients Information:

Patient ISN: 315224
Date of birth: unknown
Eligibility Status: Detainee
Attending Physician: (b)(6)
Request submitted by: (b)(6)

3. Members in attendance:

(b)(6)

4. Reason for consultation: Terminal lung cancer with metastasis to the brain. Review for end of life care.

5. Relevant medical information: Patient is a 43 year old detainee who was captured in 3/07. His screening chest xray revealed a mass, which upon further evaluation was found to be lung cancer. He was receiving supportive therapy over the course of his confinement and did well until 3/08, when a CT of his abdomen, pelvis and head revealed multiple metastases to the brain, the largest being over 4 cm in diameter. The CT also showed vasogenic edema and a ventricular shift with volume loss. The patient was treated with decadron in an effort to decrease the brain swelling. 2 days ago, he presented with new onset malaise, nausea, and headache. His chest x-ray revealed bilateral new infiltrates consistent with pneumonia, and

EXHIBIT 9

he was admitted to the hospital on IV antibiotics. Yesterday evening he became progressively more somnolent with a worsening headache, although his vital signs remained stable. Around 2300 hours yesterday, he was found to be unresponsive to pain and had one dilated pupil and decorticate movements. This morning, both pupils were found to be fixed and dilated, and he was minimally responsive to deep pain with a GCS of 5. In summary, this is a detainee with terminal lung cancer with brain metastases and likely recent brain herniation, for which there is no available treatment. The committee was presented with the question of whether to pursue aggressive treatment or comfort care measures only. Furthermore, the committee discussed the issue of notifying the family and potentially releasing the body to them after the detainee's death. The detainee has a Compassionate Release in progress; the status of this is being verified by the MPs. While this detainee had previously been denied compassionate release, there is reason to believe that our most recent request had been approved and was pending acceptance of detainee by a family member.

6. Summary of discussion: All agreed that further care or intervention would be futile. The committee unanimously agreed that comfort care only was appropriate. The committee further agreed that the family should be notified of the detainee's condition and potentially allowed to visit the detainee and claim his body after his death.

7. Was a consensus reached by the committee? Yes X No ___

8. Consensus opinion: Continue comfort care only. Ascertain status of Compassionate Release (b)(6) is working on this and will provide an answer to us ASAP). Recommend that the DCCS gives permission to have (b)(6) speak to the family and inform them of the detainee's condition. Recommend that the DCCS request TF 134 permission to release the detainee's body to the family after his death.

9. Differing opinions (only if no consensus is reached): None

10. Date and time opinion provided to DCCS: 31 July 2008

11. Approved by: (b)(6)

(b)(6)

CONVOY LIST OF REMAINS OF DECEASED PERSONNEL

PRIVACY ACT STATEMENT

AUTHORITY: 10 USC Sections 1481 through 1488, EO 9397, Nov. 1943 (SSN). 0022-33-312789-53207

PURPOSE AND USE: This form is used to establish initial identification of deceased personnel.

DISCLOSURE: Personal information provided on this form is given on a voluntary basis. Failure to provide this information, however, may result in improper identification of the deceased person and person making visual identification.

1. FROM	2. TO	3. DATE PREPARED (YYYYMMDD)	4. PAGE
BIAP MACP, Baghdad, Iraq	Next of kin	20080820	1 OF 1 PAGES

5. VEHICLE/AIRCRAFT ID NUMBER	6. EVACUATION NUMBER	7. TENTATIVELY IDENTIFIED DECEDENT (If unidentified, so state) a. NAME (Last, First, Middle Initial)	b. GRADE	c. SSN	d. ORGANIZATION
MA-08	263-08	BTB: Hasan, Mahmud Rashid	Detainee	600-00-5040	Host Nation
		Nothing Follows			

8. AIRCRAFT/VEHICLE DEPARTED	9. AIRCRAFT/VEHICLE COMMANDER a. NAME (Last, First, Middle Initial)	b. GRADE	c. ORGANIZATION
a. TIME 10:35 L	(b)(6)		
b. DATE (YYYYMMDD) 20080820	(b)(6)		e. DATE SIGNED (YYYYMMDD) 20080820

10. AIRCRAFT/VEHICLE ARRIVED	11. RECEIVING OFFICIAL a. NAME (Last, First, Middle Initial)	b. GRADE	c. ORGANIZATION
a. TIME 12:30 L		CIV	N.O.K.
b. DATE (YYYYMMDD) 20080820	(b)(6)		e. DATE SIGNED (YYYYMMDD)

FOR OFFICIAL USE ONLY

LAW ENFORCEMENT SENSITIVE

ACLU DDII CID ROIS 37303

DD FORM 1075, PREVIOUS EDITION MAY BE USED. ARD PE v1.00

EXHIBIT

ULTI-NATIONAL FORCES - IRA

0022-08-CID789-53207

The Multinational Force-Iraq deeply regrets the loss of your loved one and wishes the return of the human remains of Hasan Mahmud Rashid to his/her primary next of kin. The remains have been treated with the same respect and courtesies required by Muslim or Christian tradition and have been treated with the same respect and courtesy as those of the Coalition forces. The person receiving the remains acknowledges that Coalition forces have provided the remains in a respectful manner. Any perceived violation of local customs is wholly unintentional on the part of Coalition forces. All personal effects that were found with the remains are being turned over and an inventory is attached.

القوات المتعددة الجنسية - العراق تتقدم بكل الأسف العميق والأعتذار لفقدان احبايكم و تتمنى ان تقدم و ترجع اليكم البقايا الادمية الخاصة بالمرحوم\ .....
الى نسب اهلة القريب الاولى الية. مع العلم بأن البقايا الادمية تم معاملتها بكل الاحترام واللطف التى تتطلبها تقاليد وعادات الديانة الاسلامية او الديانة المسيحية و تمت معاملتها بنفس المعاملة التى تلقاها الموتى من قوات التحالف. الشخص المتسلم للبقايا الادمية يدرك جيدا بان قوات التحالف قامت بالعمل اللازم و بكل اساليب الاحترام التامة.
و فى حالة وجود او ادراك آية انتهاك للعادات و التقاليدالمحلية فبكل الاسف انة ليس عمدا و غير مقصود كليا من جانب قوات التحالف.
مع العلم جميع المتاع الشخصية التى وجدت مع البقايا سوف ترجع اليكم بالقائمة المرفقة.

اسم الشخص للتاكد و اثبات االبقايا الدمية \ ... (b)(6) .....
Person verifying identity

اسم الشخص المستلم \ ..... (b)(6) .....
Person receiving remains

العلاقة بالمرحوم \ ..... (b)(6) .....
Relationship to deceased

التاريخ \ 2008 08 20 .....
Date

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ACLU DDII CID ROIS 37304

EXHIBIT II

AGENT'S INVESTIGATION REPORT

CID Regulation 195-1

ROI NUMBER
0022-08-CID789-53207

DETAILS

About 1017, 28 Oct 08, SA [redacted] (b)(6), (b)(7)(C) received the Autopsy Examination Report, Toxicology Report, and Death Certificate (Overseas), pertaining to Mr. HASAN. The Autopsy Report documented the cause of death to be Metastatic Carcinoma, and the manner of death was Natural. ///Last Entry///

TYPED AGENT'S NAME AND SEQUENCE NUMBER	ORGANIZATION	
SA [redacted] (b)(6), (b)(7)(C), (b)(7)(F)	24th/348th Military Police Detachment (CID)(FWD) Camp Cropper, Baghdad, Iraq APO AE 09342	
SIG [redacted] (b)(6), (b)(7)(C)	DATE 28 Oct 08	EXHIBIT 14

(Automated)

Exhibit(s) 15 thru 17

Page(s) 000184 thru 000196 referred to:

CDR U.S. Army Medical Command
Freedom of Information/Privacy Act Office
ATTN: MCFP Bldg 126 Stop 76
1216 Stanley Road 2nd Floor
Fort Sam Houston, TX 78234-5049

ARMED FORCES INSTITUTE OF PATHOLOGY
Office of the Armed Forces Medical Examiner
1413 Research Blvd., Bldg. 102
Rockville, MD 20850
(b)(6)

AUTOPSY EXAMINATION REPORT

Name: (BTB) HASAN, Mahmud Rashid
ISN: US9IZ-315224
Date of Birth: (BTB) 1 JAN 1967
Date of Death: 31 JUL 2008
Date/Time of Autopsy: 5 AUG 2008 @ 1315 hrs
Date of Report: 10 OCT 2008

Autopsy No.: (b)(6)
AFIP No.: (b)(6)
Rank: Civilian/Detainee
Place of Death: Iraq
Place of Autopsy: Port Mortuary, Dover AFB, Dover DE

Circumstances of Death: This 41-year-old detainee was admitted to the combat hospital ICU complaining of weakness, nausea, and headaches. He was initially diagnosed with pneumonia and was treated with antibiotics. His condition continued to decline and he progressed into a coma. The preliminary diagnosis for his condition was lung cancer with brain metastasis. He was pronounced dead on 21 JUL 2008.

Authorization for Autopsy: Armed Forces Medical Examiner, per U.S. Code 10, Section 1471

Identification: Presumptive identification per CID investigation.

CAUSE OF DEATH: METASTATIC CARCINOMA

MANNER OF DEATH: NATURAL

EXHIBIT 15

EXTERNAL EXAMINATION

The body is that of a well-developed, well-nourished nude male. The body weighs 126 pounds, measures 67 inches in length, and appears compatible with the reported age of 41 years. The body is cold. Rigor is present to an equal degree in all extremities. Lividity is present and fixed on the posterior surface of the body, except in areas exposed to pressure.

The head is normocephalic, and the scalp hair is black/grey. Facial hair consists of black/grey mustache and beard. The irides are brown. The corneae are cloudy. The conjunctivae and sclerae are unremarkable. The external auditory canals, external nares and oral cavity are free of foreign material and abnormal secretions. The nasal skeleton and maxilla are palpably intact. The lips are without evident injury. There are lower partial dentures and the upper teeth are natural. Examination of the neck reveals no evidence of injury.

The chest is unremarkable. No evidence of injury of the ribs or the sternum is evident externally. The abdomen is unremarkable. No healed surgical scars are noted. The external genitalia are those of an adult male. The posterior torso and anus are unremarkable.

Callous formation is present on the base of the feet. The fingernails are intact.

CLOTHING AND PERSONAL EFFECTS

None identified.

MEDICAL INTERVENTION

- EKG leads on left lateral arm and left lower abdominal quadrant
- Numerous needle puncture marks surrounded by contusions measuring up to 2 ½ inches in maximum dimension involving the bilateral antecubital fossae, bilateral anterior forearms, and anterior right wrist

RADIOGRAPHS

A complete set of postmortem radiographs is obtained and demonstrates the following abnormalities listed below.

EVIDENCE OF INJURY

None identified at autopsy.

INTERNAL EXAMINATION

BODY CAVITIES:

No abnormal collections of fluid are present in any of the body cavities. All body organs are present in normal anatomical position. The subcutaneous fat layer of the abdominal wall is 2 inches thick.

HEAD (CENTRAL NERVOUS SYSTEM) AND NECK:

See "Neuropathology Consultation" Report below. The galeal and subgaleal soft tissues of the scalp are free of injury. There are no skull fractures. The dura mater and falx cerebri are intact. The leptomeninges are thin and delicate. The cerebral hemispheres are symmetrical. The structures at the base of the brain, including cranial nerves and blood vessels are intact.

The brain weighs 1450 grams and has edematous gyri and sulci. The atlanto-occipital joint is stable. The anterior strap muscles of the neck are homogenous and red-brown, without hemorrhage by layer-wise dissection. The thyroid cartilage and hyoid bone are intact. The larynx is lined by intact tan mucosa. The tongue is free of bite marks, hemorrhage, or other injuries. Incision and dissection of the posterior neck demonstrates no deep paracervical muscular injury and no cervical spine fractures.

CARDIOVASCULAR SYSTEM:

The 360gram heart is contained in an intact pericardial sac. The epicardial surface is smooth, with minimal fat investment. The coronary arteries are present in a normal distribution, with a right-dominant pattern. Cross sections of the vessels show mild (less than 25%) focal atherosclerotic luminal stenosis of the left anterior descending coronary artery and the others are unremarkable.

The myocardium is homogenous, red-brown, and firm. The valve leaflets are thin and mobile. The walls of the left ventricle, interventricular septum, and right ventricle are 1.2, 0.8, and 0.2 centimeter thick, respectively. The endocardium is smooth and glistening. The aorta displays atherosclerotic streaks and gives rise to three intact and patent arch vessels. The renal and mesenteric vessels are unremarkable.

RESPIRATORY SYSTEM:

The upper airway is clear of debris and foreign material: the mucosal surfaces are smooth, yellow-tan and unremarkable. There is a right upper lobe pleural adhesion and the remaining surface showing a smooth, glistening appearance. The pulmonary parenchyma displays multiple tan lesions measuring up to 0.7 centimeters in maximum dimension involving the right upper, left upper, and left lower lobes of the lungs. The pulmonary arteries are normally developed, patent and without thrombus or embolus. The right lung weighs 780grams and the left lung weighs 650 grams.

HEPATOBILIARY SYSTEM:

The 1520 grams liver has an intact smooth capsule covering moderately congested tan-brown parenchyma with multiple tan lesions measuring up to 1 centimeter in maximum dimension.

The gallbladder contains 6 milliliters of green-brown, mucoid bile; the mucosa is velvety and unremarkable. The extrahepatic biliary tree is patent, without evidence of calculi.

GASTROINTESTINAL SYSTEM:

The esophagus is lined by gray-white, smooth mucosa. The gastric mucosa is arranged in the usual rugal folds and the lumen contains 150 milliliters of green fluid. The small and large bowels are unremarkable. The pancreas has a normal pink-tan lobulated appearance and the ducts are clear. The appendix is present.

GENITOURINARY SYSTEM:

The right and left kidneys weighs 90 grams. The renal capsules are smooth and thin, semi-transparent and strip with ease from the underlying smooth, red-brown cortical surface. There are multiple tan lesions in both kidneys which measure up to 1 centimeter in maximum dimension. The cortices are sharply delineated from the medullary pyramids, which are red-purple to tan and unremarkable. The calyces, pelves and ureters are unremarkable. The tan bladder mucosa overlies an intact bladder wall. The bladder contains no urine. The testes, prostate gland and seminal vesicles are unremarkable.

LYMPHORETICULAR SYSTEM:

The spleen weighs 50 grams has a smooth, intact capsule covering red-purple, moderately firm parenchyma; the lymphoid follicles are unremarkable. Lymph nodes in the hilar, periaortic and iliac regions are not enlarged.

ENDOCRINE SYSTEM:

The pituitary gland is left *in situ* and is unremarkable. The thyroid gland is symmetric and red-brown, without cystic or nodular change. The left adrenal gland has a tan lesion that measures 0.8 centimeter in maximum dimension. The right adrenal gland is unremarkable.

MUSCULOSKELETAL SYSTEM:

No non-traumatic abnormalities of muscle or bone are identified.

MICROSCOPIC EXAMINATION

Selected portions of organs are retained in formalin, with preparation of histology slides:

Right Upper Lobe (slide 1), Right Middle and Lower lobes of lung (slide 2), Liver (slide 3), left lower lobe of lung (slide 4), left upper lobe and spleen (slide 5), left kidney (slide 6), left adrenal (slide 7), and right kidney (slide 8): sections of the organs display areas of metastatic carcinoma with pleomorphic nuclei admixed with necrosis. The spleen and right middle/left lower lobes of the lung displayed on metastatic involvement.

ADDITIONAL PROCEDURES

1. Documentary photographs are taken by OAFME.
2. Personal effects are released to the appropriate mortuary operations representatives.
3. Specimens retained for toxicology testing and/or DNA identification are: vitreous fluid, blood, bile, gastric contents, spleen, liver, lung, kidney, myocardium, adipose tissue and skeletal muscle.
4. The dissected organs are forwarded with body.

NEUROPATHOLOGY CONSULTATION

FINAL DIAGNOSIS

GROSS DESCRIPTION:

Brain weight: 1437 gm

The specimen consists of the intracranial dura and brain of an adult.
The intracranial dura is not remarkable. The venous sinuses are patent.
The brain is markedly swollen with wide, flattened gyri and compressed sulci. The perisellar, perimesencephalic and basal cisterns are completely effaced due to swelling. Deep tentorial grooves indent each uncus approximately 1 cm from the medial margin on the right and 0.8 cm on the left due to downward transtentorial pressure. The cerebellar tonsils are deeply molded by the foramen magnum due to downward trans-foramen magnum intracranial pressure. A regional nonhemorrhagic (artefactual) disruption of a 4 x 4.5 cm area of the right lateral parietal lobe communicates with an approximately 5 x 5 x 4.5 cm cavity of the right posterior/inferior frontal and anterior occipital lobe white matter. Accompanying the brain is a firm, friable, 4.5 x 5 x 4 cm pink-tan neoplastic mass consistent with metastatic neoplasm, with diffuse necrotic, granular yellow-white cut surfaces which has been artifactually extruded from the above noted right frontal occipital cerebral cavity.

The leptomeninges are thin, delicate and transparent. The midbrain and pons are markedly enlarged. The arteries at the base of the brain follow a normal distribution and there are no aneurysmal dilatations or sites of occlusion. All the identifiable cranial nerve roots are not remarkable.

Coronal sections of the cerebrum reveal marked white matter edema and swelling of the right frontal lobe associated with the above noted neoplasm with effacement of the

gray/white matter margins and right trans-falcine cingulate gyrus herniation due to leftward pressure across the falx cerebri. The adjacent right lateral ventricle is partially collapsed and the opposite left ventricle is enlarged reflecting partial compression of the left foramen of Munro.

A second granular friable mass (3.5 x 4 x 3.5 cm), similar to the above described lesion is situated in the posterior-inferior right frontal lobe and invades the lateral basal ganglia and the sub-insular cortex.

There is multifocal hemorrhage and necrosis of the right inferior thalamus and the bilateral subependymal areas of each thalamus. A 0.3 to 0.5 cm thick layer of granular, friable neoplastic tissue similar to the above lesions encases the occipital horn of the left lateral ventricle.

Sections of the midbrain and pons show marked swelling due to tegmental Duret hemorrhages and necrosis. The tegmentum of the medulla is edematous. The substantia nigra and locus coeruleus are well pigmented.

PHOTOGRAPHS: yes

MICROSCOPIC EXAMINATION:

Blocks of tissue for microscopic examination are removed from: (1) right lateral frontal lobe, (2) right striate body, (3) right insular tumor, (4) right lateral parietal lobe, (5) external tumor, (6) pons, (7) cerebellum, (8) left occipital lobe, (9) medulla, (10) dura and (11) right hippocampus.

Sections from each block are stained with H&E, Bielschowsky and LFB techniques and immunostained for β–APP, GFAP, β–amyloid, Tau-2, ubiquitin, synuclein.

DIAGNOSIS:

Multifocal (right frontal, right parietal/occipital, left occipital) metastatic, anaplastic, necrotic carcinoma with:

1. Extensive perineoplastic edema
2. Trans-falcine (leftward), trans-tentorial and trans foramen magnum herniation
3. Duret hemorrhage of midbrain and rostral pons tegmentum.
4. Partial obstruction of left foramen of Munro

(b)(6)

NEUROPATHOLOGIST

FINAL AUTOPSY DIAGNOSES

I. Metastatic Carcinoma
- A. Multifocal (right frontal, right parietal/occipital, left occipital) lesions of the brain
- B. Carcinoma with pleomorphic nuclei admixed with necrosis
- C. Extensive perineoplastic edema
- D. Trans-falcine (leftward), trans-tentorial and trans-foramen magnum herniation
- E. Duret hemorrhage of midbrain and rostal pons tegmentum
- F. Partial obstruction of left foramen of Munro
- G. Tumor involvement of the bilateral lungs, left adrenal gland, liver, and kidneys

II. Pre-existing Natural Disease:
- A. Bilateral emphysematous lungs
- B. Atherosclerotic cardiovascular disease
  1. Left anterior deceasing, focal/mild
  2. Aorta, atherosclerotic streaks present

III. Evidence of Medical Therapy: As described above

IV. Post-Mortem Changes: As described above

V. Identifying Body Marks: None identified

VI. Toxicology (AFIP):
- A. VOLATILES: No ethanol detected in the blood and vitreous fluid
- B. DRUGS: No screened drugs of abuse/medications detected in the urine
- C. CYANIDE: No cyanide detected in the blood
- D. CARBON MONOXIDE: Carboxyhemoglobin saturation in the blood was less than 1%.

OPINION

This 41-year-old detainee, Mahmud Hasan, died of clinically diagnosed lung cancer which spread (metastasized) to the brain, left adrenal gland, liver, and kidneys. The primary tumor was not identified in the lungs. However, the metastasized tumors were of the adenocarcinoma type which is consistent with occult lung tumor. At autopsy, the body did not display evidence of blunt or sharp force injury to suggest foul play. The toxicology screen is negative. The manner of death is natural.

(b)(6)
(b)(6) Medical Examiner

(b)(6)
(b)(6)
17OCT2008
(b)(6) Medical Examiner

DEPARTMENT OF DEFENSE
ARMED FORCES INSTITUTE OF PATHOLOGY
WASHINGTON, DC 20306-6000

REPLY TO ATTENTION OF

0022-08-CID789-53207

AFIP-CME-T

PATIENT IDENTIFICATION

AFIP Accessions Number (b)(6) **Sequence** (b)(6)

Name BTB HASAN, MAHMUD RASHID

SSN: **Autopsy:** (b)(6)

Toxicology Accession # (b)(6)

Date Report Generated: August 11, 2008

TO:

OFFICE OF THE ARMED FORCES MEDICAL EXAMINER
ARMED FORCES INSTITUTE OF PATHOLOGY
WASHINGTON, DC 20306-6000

CONSULTATION REPORT ON CONTRIBUTOR MATERIAL

AFIP DIAGNOSIS **REPORT OF TOXICOLOGICAL EXAMINATION**

Condition of Specimens: GOOD
Date of Incident: 7/31/2008 **Date Received:** 8/7/2008

CARBON MONOXIDE: The carboxyhemoglobin saturation in the blood was less than 1% as determined by spectrophotometry with a limit of quantitation of 1%. Carboxyhemoglobin saturations of 0-3% are expected for non-smokers and 3-10% for smokers. Saturations above 10% are considered elevated and are confirmed by gas chromatography.

VOLATILES: The **BLOOD AND VITREOUS FLUID** were examined for the presence of ethanol at a cutoff of 20 mg/dL. No ethanol was detected.

CYANIDE: There was no cyanide detected in the blood. The limit of quantitation for cyanide is 0.25 mg/L. Normal blood cyanide concentrations are less than 0.15 mg/L. Lethal concentrations of cyanide are greater than 3 mg/L.

DRUGS: The **BLOOD** was screened for acetaminophen, amphetamine, antidepressants, antihistamines, barbiturates, benzodiazepines, cannabinoids, chloroquine, mefloquine, cocaine, dextromethorphan, lidocaine, narcotic analgesics, opiates, phencyclidine, phenothiazines, salicylates, sympathomimetic amines and verapamil by gas chromatography, color test or immunoassay. The following drugs were detected:

None were found.

(b)(6)

Office of the Armed Forces Medical Examiner

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0022-08-CID789-53207

[redacted] FORENSIC TOXICOLOGY - TOXICOLOGY [redacted]

TO:	FORWARD I
ARMED FORCES INSTITUTE OF PATHOLOGY ATTN: DIVISION OF FORENSIC TOXICOLOGY BUILDING 54 6825 16TH STREET, N.W. WASHINGTON, DC 20306-6000	Dover AFB Port Mortuary Incident : OIF (b)(6) Remains/Case #: (b)(6) Recovery/TC #: Process Date: 05 Aug 08 ME # (b)(6)

NAME OF PATIENT (Last, First, MI)	SOCIAL SECURITY #	AGE	SEX	RACE
BTA HNAN, MAHMUD R	ISN 315224			

DATE OF INCIDENT/ACCIDENT	TIME OF INCIDENT OR DEATH	[redacted]
31 JUL 08	31 JUL 08	ME (b)(6)

[redacted]

[redacted]	[redacted]	
1. Vitreous	5. Adrenal	9. Bile
2. ~~Spinal~~ cerr ~~Muscle~~	6. ~~Urine~~ cerv TIT	10. Spleen
3. Blood	7. Liver	11. Gastric
4. Lung	8. Heart	12. Kidney

[redacted]

DFT#
08-5416

[redacted]	[redacted]		
(b)(6)	(b)(6)	SAUG 08	

[redacted] CHAIN OF CUSTODY [redacted]

[redacted]	[redacted]		
(b)(6) (b)(6) HAND CARRIED (b)(6) (b)(6)	(b)(6) (b)(6) Secured Storage	AUG 0 7 2008 e0810 AUG 0 7 2008 e0810	Received From Courier TOXICOLOGY TESTING SECURED STORAGE

EXHIBIT 16

CERTIFICATE OF DEATH *(OVERSEAS)*
Acte dé décès (D'Outre-Mer) 0022-08-CIU789-53207

NAME OF DECEASED *(Last, First, Middle)* Nom du décédé (Nom et prénoms)	GRADE Grade	BRANCH OF SERVICE Arme	SOCIAL SECURITY NUMBER Numéro de l'Assurance Social
BTB Hasan, Mahmud, Rashid		Civilian	9IZ-31-5224
ORGANIZATION Organisation	NATION *(e.g, United States)* Pays: Iraq	DATE OF BIRTH Date de naissance: 1 January 1967	SEX Sexe: [X] MALE [ ] FEMALE

RACE Race		MARITAL STATUS État Civil				RELIGION Culte			
X	CAUCASOID Caucasique		SINGLE Célibataire		DIVORCED Divorcé		PROTESTANT Protestant	X	OTHER (Specify) Autre (Spécifier): Islam
	NEGROID Negriode		MARRIED Marié		SEPARATED Séparé		CATHOLIC Catholique		
	OTHER (Specify) Autre (Spécifier)		WIDOWED Veuf				JEWISH Juif		

NAME OF NEXT OF KIN Nom du plus proche parent	RELATIONSHIP TO DECEASED Parenté du décéde avec le sus
STREET ADDRESS Domicilé à (Rue)	CITY OR TOWN OR STATE *(Include ZIP Code)* Ville (Code postal compris)

MEDICAL STATEMENT Déclaration médicale

CAUSE OF DEATH (Enter only one cause per line) Cause du décès (N'indiquer qu'une cause par ligne)		INTERVAL BETWEEN ONSET AND DEATH Intervalle entre l'attaque et le décès
DISEASE OR CONDITON DIRECTLY LEADING TO DEATH[1] Maladie ou condition directement responsable de la mort.[1]	Metastatic carcinoma	
ANTECEDENT CAUSES Symptômes précurseurs de la mort. — MORBID CONDITION, IF ANY, LEADING TO PRIMARY CAUSE Condition morbide, s'il y a lieu. menant à la cause primaire		
UNDERLYING CAUSE, IF ANY, GIVING RISE TO PRIMARY CAUSE Condition morbide, s'il y a lieu. menant à la cause primaire		
OTHER SIGNIFICANT CONDITIONS[2] Autres conditions significatives[2]		

MODE OF DEATH Condition de décès	AUTOPSY PERFORMED Autopsie effectuée [X] YES Oui [ ] NO Non	CIRCUMSTANCES SURROUNDING DEATH DUE TO EXTERNAL CAUSES Circonstances de la mort suscitées par des causes extérieures
X NATURAL Mort naturelle	MAJOR FINDINGS OF AUTOPSY Conclusions principales de l'autopsie	
ACCIDENT Mort accidentelle		
SUICIDE Suicide	NAME OF PATHOLOGIST Nom du pathologiste: (b)(6)	
HOMICIDE Homicide	SIGNATURE Signature / DATE Date: 5 August 2008	AVIATION ACCIDENT Accident á Avion [ ] YES Oui [X] NO Non

DATE OF DEATH *(day, month, year)* Date de décès (le jour, le mois, l'année)	PLACE OF DEATH Lieu de décès
31 July 2008 1605	Camp Cropper Iraq

I HAVE VIEWED THE REMAINS OF THE DECEASED AND DEATH OCCURRED AT THE TIME INDICATED AND FROM THE CAUSES AS STATED ABOVE.
J'ai examiné les restes mortels du dé funtet je conclus que le décès est survenu à l'heure indiquée et à, la suite des causes énumérées ci-dessus.

NAME OF MEDICAL OFFICER Nom du médicin militaire ou du médicin sanitaire	TITLE OR DEGREE Titre ou diplômé
(b)(6)	(b)(6)
GRADE Grade: (b)(6)	INSTALLATION OR ADDRESS Installation ou adresse: Dover AFB, Dover DE
DATE Date: 10/24/2008	SIGNATURE Signature

1 State disease, injury or complication which caused death, but not mode of dying such as heart failure, ect.
2 State conditions contributing to the death, but not related to the disease or condition causing death.
1 Préciser la nature de la maladie, de la blessure ou de la complication qui a contribué à la mort, mais non la manière de mourir, telle qu 'un arrêt du coeur, etc
2 Préciser la condition qui a contribué à la mort, mais n'ayant aucun rapport avec la maladie ou à la condition qui a provoqué la mort.

DD FORM 1 APR 77 2064 REPLACES DA FORM 3565, 1 JAN 72 AND DA FORM 3565-R(PAS), 26 SEP 75, WHICH ARE OBSOLETE.

EXHIBIT 17

(REMOVE, REVERSE AND RE-INSERT CARBONS BEFORE COMPLETING THIS SIDE)

DISPOSITON OF REMAINS 0022-08-CID789-53207

NAME OF MORTICIAN PREPARING REMAINS	GRADE	LICENSE NUMBER AND STATE	OTHER

INSTALLATION OR ADDRESS	DATE	SIGNATURE
436 SVC/SVD 116 26th Street, Dover AFB DE 19902		

NAME OF CEMETERY OR CREMATORY	LOCATION OF CEMETERY OR CREMATORY

TYPE OF DISPOSTION	DATE OF DISPOSTION

REGISTRATION OF VITAL STATISTICS

REGISTRY *(Town and Country)*	DATE REGISTERED	FILE NUMBER	
		STATE	OTHER

NAME OF FUNERAL DIRECTOR	ADDRESS

SIGNATURE OF AUTHORIZED INDIVIDUAL

DD FORM 2064, APR 1977 (BACK) *USAPA V1.00*